U.S. DEPARTMENT OF VETERANS AFFAIRS GRANT AND PER DIEM PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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U.S. DEPARTMENT OF VETERANS AFFAIRS GRANT AND PER DIEM PROGRAM

THURSDAY, SEPTEMBER 27, 2007

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Salazar, and Miller.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. The Subcommittee on Health will come to order.

I would like to thank everyone for coming today. Today we will examine the U.S. Department of Veterans Affairs (VA) Grant and Per Diem (GPD) Program for homeless veterans.

On any given night, there are approximately 200,000 homeless veterans on the streets in America. The majority of these veterans served in Vietnam. Ninety-six percent are male and about 45 percent suffer from mental illness.

VA has many programs to help homeless veterans including the Grant and Per Diem Program. VA needs to continually evaluate these programs to ensure that veterans are getting the services that they need and that provider organizations can effectively provide these services as well.

For example, while the vast majority of homeless veterans are male, female veterans are the fastest-growing segment in this population. Women homeless veterans face similar challenges to their male counterparts, but they are very likely to have experienced serious trauma including abuse or rape and a significant number also have children to support. VA programs must be flexible to meet this new challenge.

I believe that the VA should make sure that they give community-based organizations the tools they need to provide comprehensive service to our homeless veterans. The way in which the Grant and Per Diem Program is currently structured sometimes make this difficult, particularly for providers in high-cost areas.

It is my belief that the goal of the VA homeless program should be not only to provide veterans with a bed for the night and a meal, but to provide them with the resources they need to attain permanent housing and a steady job and a renewed sense of self-worth.

Today I hope that we will learn what VA is doing to provide service to homeless veterans to help them break out of this cycle. We will hear from the Grant and Per Diem Program on what is working and the ways that it can be changed. This is a problem that we can solve by working together. One homeless veteran is too many.

[The prepared statement of Chairman Michaud appears on p. 30.]

Mr. MICHAUD. I would now like to recognize a colleague of mine who cares deeply about our veterans, Ranking Member Miller, for any opening statement he might have.

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman.

This year marks the 20th anniversary of VA providing specialized services for homeless veterans. VA's homeless program began in 1987 with Public Law 100–6, which provided VA with $5 million to support care for veterans in community-based and domiciliary facilities.

Since that time, VA's homeless programs have expanded and grown significantly. VA currently budgets almost $2 billion to treat and assist homeless veterans, and administers over 9 specialized programs that integrate housing and mental health and substance abuse counseling.

Although it remains difficult to obtain an accurate count of the number of homeless veterans, and I think most of us agree that 200,000 is a close number. There are indications that we are making good progress in helping reintegrate homeless veterans into stable community environments and lead productive and sober lives.

Still, there are far too many veterans out on the street. I concur with you, Mr. Chairman, that one homeless veteran on any given night is too much. On any given night in my home State of Florida, there are 17,000 homeless veterans are on the streets.

I think that with the increasing number of returning veterans from the conflicts in Iraq and Afghanistan, the development of innovative services to help veterans at-risk for homelessness is extremely important.

Today, we meet to review VA's Homeless Providers Grant and Per Diem (GPD) Program. This program is considered to be a very successful collaboration between VA, nonprofit, and faith-based organizations. Our Committee has always worked in a bipartisan manner to strengthen healthcare, housing, employment training, and other services to assist at-risk veterans. Mr. Chairman, I look forward to working with you to continue that relationship.

I would like to welcome all of the witnesses that are here with us today, especially Kathryn Spearman who is with Volunteers of America Florida, for participating in our hearing this morning. I am grateful for her dedication and many years of service and work to provide services that assist homeless veterans in our home State of Florida.

Mr. Chairman, I yield back the balance of my time.

[The prepared statement of Congressman Miller appears on p. 30.]

Mr. MICHAUD. I thank the gentleman.

Our first panel today is Cheryl Beversdorf who is President and Chief Executive Officer (CEO) of the National Coalition for Homeless Veterans (NCHV).

Welcome, Cheryl.

And Kathryn Spearman who is President and CEO of Volunteers of America from Tampa, Florida.

I also want to welcome you, Kathryn.

And Daniel Bertoni who is Director of Education, Workforce and Income Security Issues from the U.S. Government Accountability Office (GAO).

I would like to welcome our panelists today and we will start off with Cheryl and just work down.

So I turn the floor over to you.

STATEMENTS OF CHERYL BEVERSDORF, RN, MHS, MA, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL COALITION FOR HOMELESS VETERANS; KATHRYN E. SPEARMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VOLUNTEERS OF AMERICA OF FLORIDA; AND DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE AND INCOME SECURITY ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF CHERYL BEVERSDORF

Ms. BEVERSDORF. The National Coalition for Homeless Veterans appreciates the opportunity to submit testimony to the Health Subcommittee of the House Veterans' Affairs Committee regarding the VA Grant and Per Diem Program.

NCHV's membership represents nearly 280 community-based organizations in 48 States and the District of Columbia. As a network, NCHV members provide the full continuum of care to homeless veterans and their families including emergency shelter, food and clothing, healthcare, addiction and mental health services, employment support, educational assistance, legal aid and transitional housing and other kinds of services.

NCHV members serve approximately 150,000 veterans annually. Regarding homelessness among veterans, the VA reports homeless veterans are mostly males, although 3 percent are females, and the vast majority are single, although service providers are reporting an increased number of veterans with children seeking their assistance.

About half of all homeless veterans have a mental illness and more than two-thirds suffer from alcohol or other substance abuse problems. Nearly 40 percent have both psychiatric and substance abuse disorders.

In addition, the majority of women in homeless veteran programs have serious trauma histories, some life threatening, and many of these women have been raped and reported physical harassment while in the military.

Veterans are at high risk of homelessness due to 3 factors: Extremely low or no livable income; extreme shortage of affordable housing; and limited access to healthcare. These factors combined with circumstances experienced during their military service put them at even greater risk of homelessness.

Findings from a 2006 NCHV survey suggest the homeless veteran population in America is experiencing significant changes. Homeless veterans receiving services today are aging and many need permanent supportive housing. With more women in the military, the percentage of women veterans seeking services is increasing.

In general, a growing number of combat veterans returning home from Iraq and Afghanistan, both men and women, are suffering from war-related conditions including post traumatic stress disorder (PTSD) and traumatic brain injury (TBI), which may put them at risk for homelessness.

The homeless providers Grant and Per Diem Program supports development of transitional community-based housing and delivery of supportive services for homeless veterans through competitive grants to community-based, faith-based, and public organizations.

To underline the importance of the Grant and Per Diem Program, in September 2006, the GAO released a study that found while VA has attempted to improve its services and increase the capacity of the Grant and Per Diem Program, an additional 9,600 transitional housing beds are still needed to meet current demand.

Regarding Grant and Per Diem appropriations, NCHV is pleased both the House and Senate have passed bills increasing the fiscal year 2008 appropriations to the fully authorized level of $130 million. If approved, funding at this level will increase beds available to serve more men and women veterans at risk of homelessness.

In addition to the need for more beds and increased program funding, NCHV believes the mechanism for paying providers under the Grant and Per Diem Program must be modified.

Regarding payment, many Grant and Per Diem providers report even the maximum rate of up to $31.30 provides far less than the actual daily cost of care to a veteran in the Grant and Per Diem Program.

Providers often experience lengthy, ongoing communication with the VA and questions regarding expenses incurred and accountability resulting in a delay in timely reimbursement and ultimately, interruption of services to their clients.

The accounting burden is particularly onerous for smaller faith-based and community-based organizations that may lack the necessary resources to easily resolve these issues.

At the time the law creating the Grant and Per Diem Program was written, Congress had limited knowledge as to how services to veterans outside VA facilities should be reimbursed. As a result, the rate authorized for State homes for domiciliary care was used as the standard for paying homeless veterans' service providers.

Over time, evidence has shown clients in the two settings have very different needs. Accordingly, a modified payment system that reflects the special needs of homeless veterans and the comprehensive services they receive must be applied.

Whereas residents receiving domiciliary care in State homes are more likely to remain permanently in VA facilities, the goal of community-based veteran service providers is to promote independent living for their clients and reintegration back into civilian life.

To address these issues, NCHV urges Congress to introduce legislation that would allow payments for services to be related to costs rather than a capped rate.

In addition to creating a more user-friendly system, this approach may increase service provider participation in high-cost service areas.

A reasonable practice of outcome and performance measurement of Grant and Per Diem providers should be included under this system.

The requirements for grant recipients should also allow service providers to use other available sources of income besides the Grant and Per Diem Program including payments or grants from other Federal departments and agencies in addition to those of State or local governments.

While the current law was intended to ensure VA per diem payments do not replace payments or contributions from other income sources, it has instead created the unintended consequences of penalizing Grant and Per Diem providers successful in securing other sources of income for services to homeless veterans by reducing their per diem payment rate.

Congress should devise a payment provision that encourages Grant and Per Diem providers to seek funding from the non-VA sources in a manner that does not penalize them if they are successful.

All payment modifications should also allow VA funds to be used as a match or leverage for other Federal funds and allow other Federal funds to be used without offset by VA.

When Grant and Per Diem providers are able to receive the maximum rate in addition to other income sources, they can expand the scope and quantity of services to homeless veterans and increase the likelihood of their successful reintegration into the community.

Additional income will help providers develop and support additional housing units, provide veterans a more robust service package, and serve homeless veterans not qualified for Grant and Per Diem support.

In conclusion, I want to thank you for inviting NCHV to present our views about the Grant and Per Diem Program. We urge Congress to introduce and pass legislation that will address the concerns that we have presented today.

I will be happy to answer your questions.

[The prepared statement of Ms. Beversdorf appears on p. 31.]

Mr. MICHAUD. Ms. Spearman.

STATEMENT OF KATHRYN E. SPEARMAN

Ms. SPEARMAN. Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee, thank you for the invitation to testify today and for all you do to assist our Nation's veterans.

I work for Volunteers of America of Florida, as stated earlier, which is a statewide faith-based social service organization in Florida for the past 87 years. And we are an affiliate of the larger Volunteers of America, a national organization around for 111 years and with affiliates in 44 States.

Volunteers of America of Florida offers housing and services and we serve multiple and different types of populations including the

homeless. Our service continuum includes housing, healthcare, training, education, employment, and services that all enhance self-sufficiency.

We currently operate in 13 Florida cities and we are in development in 3 more cities. And we do some consultation with some grass-roots groups that have a rural focus.

For my Florida Members, I would like to say, Representative Miller, we are developing Pensacola and we have some new things that are going to be going on there. So we are happy with that.

And I guess Representatives Brown and Stearns are not present right now, but we have some things in their area as well.

Florida attracts many homeless veterans and we have been focused on addressing the needs of these individuals for the past 10 years. We partner with the VA Grant and Per Diem Program in serving this population.

And as far as transitional housing and support services currently, we have a 216-bed capacity with 81 in development. And most of those are from the Grant and Per Diem. Also included are 45 U.S. Department of Housing and Urban Development (HUD) Supportive Housing Program transitional beds for veterans as well.

Our first Grant and Per Diem was a 40-foot state-of-the-art vehicle that is a fully-contained medical, dental, and health-service facility that does mobile outreach all over the State of Florida. And that is still in operation.

I would also like to say that all of our beds are filled with veterans. And I know we have the 25-percent rule, but we never had any, you know, reason to use that because the need is so great.

As far as the Grant and Per Diem Program, I would like to say some positive things that I really do appreciate as a provider.

First of all, the dedication of Roger Casey and his staff to try to keep making this program what it needs to be, the continual funding that we have been receiving recently to add more beds, the grant segment, which provides tremendous leverage and incentive, the opportunity for the VA and the community to work together to help homeless veterans, the per diem that strengthens the operations and program, the potential for the service center, and also I very much see this as a gateway for veterans to become more a part of the community.

Our 10 years of experience have led us to an increasing awareness of the issues facing the Grant and Per Diem Program and the providers. And I want to spend the rest of my testimony mentioning some information I would like to share but also a few suggestions.

In relation to partnership, the overall partnership between the VA and the community needs strengthening. Local providers address the needs of veterans every day and complement the VA's services. We are good at what we do and we need the VA and the VA needs the community providers. And the veteran needs us to work more closely together.

A partnership approach, I feel strongly does work, and with a good partnership comes shared risk because we both own the problem and work together to solve those problems.

A suggestion I would have today is a work group to advise and the task would be for a Grant and Per Diem payment mechanism

that is provider friendly and also offers the accountability that the VA needs. And the representation on that group would be all the members of the partnership.

Next—what it takes in helping homeless veterans. I think there are eleven essential services and I have listed those in my written testimony, things that I think are essential to bringing a veteran back to being a part of the community.

I doubt most people know how disengaged and disabled many of the homeless veterans are when they come to our programs and drug and alcohol addiction is very serious and disruptive to rebuilding a life acceptable in our society.

Next I want to talk about cost. The services, the eleven essential services go all the way from outreach to treatment and then integration back into the community. But the cost, I just want to say that the service cost and the payment do not match up, the $32.00 a day. And I have put some breakdowns in my written testimony to show actually what things do cost as an example.

And then the service center payment mechanism does not relate, just does not relate. We need to change that.

And then the construction, rehab and acquisition require 30 percent cash and we need more flexibility with that. There are many creative ways to combine development funding or put together the assets of providers, the VA grant and some financing.

I have proposed some options for payment possibilities in my written testimony based on experience.

I think the flexibility we need now in this program should also be with an eye to the future when we will be focused on a new era of veterans with a whole new set of circumstances and needs.

Veterans now returning from Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) should benefit from the lessons we have learned in developing support and interventions.

As we work together and address program improvements, we will be better prepared to continue to meet the needs of current homeless veterans and wisely anticipate the needs of our returning troops.

Thank you for the opportunity to share my views today.

[The prepared statement of Ms. Spearman appears on p. 34.]

Mr. MICHAUD. Thank you very much.

Mr. Bertoni.

STATEMENT OF DANIEL BERTONI

Mr. BERTONI. Good morning, Mr. Chairman, Members of the Subcommittee. Thank you for inviting me here today to discuss VA's homeless providers' Grant and Per Diem Program.

Last year, VA ordered $95 million in GPD grants to over 300 local agencies who provide transitional housing for veterans. The program is not designed to serve all homeless veterans but targets those most in need such as veterans with mental illness and substance abuse problems.

The program's goals are to help veterans achieve residential stability, increase income or skills, and greater self-determination.

My testimony today draws on our prior work and focuses on 3 areas. We have updated some of the data to bring it up to real-time time frames.

Focusing on VA's efforts to expand program capacity to meet demand, provide collaboration and challenges to serve homeless veterans, and VA's processes for gauging program effectiveness.

In summary, VA estimates that on any given night, about 196,000 veterans are homeless and in need of transitional beds. Since fiscal year 2000, the agency has increased the number of beds from about 2,000 to over 8,000 and increased the number of annual admissions from 4,800 to over 15,000.

Although the number of transitional beds available nationwide from all sources increased to more than 40,000 in 2006, VA estimates that about 11,000 more beds are needed to meet demands.

At the time of our review, the agency planned to expand the program by about 2,000 beds and to make beds available in every State. However, an important demographic shift may require VA to reassess the type of housing and services provided in the future.

Officials told us that they expect to see more homeless women veterans and more veterans with dependents in coming years, a trend that is directly related to the current makeup of our active and Reserve forces.

The providers we visited often collaborated with public and nonprofit agencies in helping veterans recover from substance abuse or mental illness and obtain permanent housing, employment, financial stability, and services to facilitate independent living.

However, some providers face challenges serving veterans such as finding affordable permanent housing for those ready to leave the program as well as transportation, legal assistance, dental care, and substance abuse treatment.

Perhaps most importantly, however, we found that some providers did not fully understand certain program eligibility requirements and stay rules which could affect the veteran's ability to get care. And VA was not consistently holding them accountable to program performance goals.

For example, some providers incorrectly believe that veterans could not participate in the program unless they were eligible for VA healthcare. Others understood the life-time limit rule of 3 stays but were unaware that waivers could, in fact, be granted.

Per our recommendation, VA has taken steps to improve communication and ensure its policies are understood by VA liaisons and providers responsible for implementing the program.

To assess program performance, VA primarily relies on measures of veterans' status at the time they leave the program rather than obtaining such information months or years later. In part, this has been due to concerns about cost, benefits, and feasibility of doing more extensive follow-up.

Generally VA's data show that since 2000, an increasing percentage of veterans met each of the program's 3 goals at the time they left the program.

During 2006, over half of veteran participants obtained independent housing. Another quarter were in transitional housing programs, halfway houses, hospitals, and nursing homes. Nearly one-third had jobs and significant percentages also demonstrated progress with alcohol and other substance abuse problems.

To obtain a more complete understanding of the program's effectiveness, we have recommended that VA explore feasible and cost-

effective ways to obtain information on how veterans are faring in the longer term.

VA is considering an approach that would allow it to obtain information of participants' status 30 days after leaving the program. While this is a step in the right direction, we continue to believe that obtaining additional information at a later point would provide a better indication of long-term program success.

Mr. Chairman, this concludes my statement. I am happy to answer any questions that you or other Members of the Subcommittee may have. Thank you.

[The prepared statement of Mr. Bertoni appears on p. 37.]

Mr. MICHAUD. I would like to thank all 3 panelists for your testimony this morning.

My first question is for Ms. Spearman. As a Grant and Per Diem Program provider, can you speak to how the reimbursement process and the restrictions have affected your ability to provide services? And I know you mentioned about setting up a work group, but do you have any specific recommendations yourself on how to make the reimbursement process less burdensome?

Ms. SPEARMAN. Well, I would say that I do not have all the answers for that. I think that there are various things on the table right now that people are looking for. But I do think that uncapping and looking at directly what the real costs are and developing a mechanism for that.

We have a lot of paperwork and a lot of monitoring that goes on and I feel like that it is excessive for the amount of money that it takes to do the program.

And I have mentioned also that the $31.30, I think that it is today, is just about what it would cost to just do the housing management or one overlay of service.

So even though the paperwork has been cumbersome, more important are the delays in getting stuff processed, I think mentioning the contract liaisons, I think that their training is hopefully going to improve that.

But another recommendation in my written comment was that we would actually have them as part of the Grant and Per Diem Program because I do not think the goals of the VA medical centers are the same so that when they are processing, I think that our concern is that the VA takes the risk with us about putting people in beds at night, if that is what they need, that we are able to process that quickly and that we share some risk that that vet may not be exactly the right person for our program or we may be able to refer them on or to bring in some additional services.

We have just made the policy to go ahead and take the person into the bed and take all the risk. VA has not been able to step forward and say we will pay, you know, due back payments on that particular veteran. So we do have that issue of the paperwork interfering there. We could go on on lots of individual things, but——

Mr. MICHAUD. Thank you.

Do you want to answer as well, Ms. Beversdorf? Are there any specific recommendations how the reimbursement process can be less burdensome?

Ms. BEVERSDORF. I believe Kathy's testimony contains recommendations worth considering. There needs to be more dialogue. Most of the time, our members are frustrated because there is not good communication between the VA liaisons at the VA medical center and service providers.

Sometimes the easy way out is for service providers to not participate in the program or providers choose not to stay in the program. That very much concerns us. Given the need for additional beds, there is a need to modify the process so more providers are willing to participate.

Mr. MICHAUD. Mr. Bertoni, you are the Director of Education, Workforce, and Income Security Issues. Are there ways that we could streamline the reimbursement process? Also, when you look at what is happening, particularly with more veterans coming back from Iraq and Afghanistan, with the Department of Labor cutting career centers, that is what they are called in Maine, how can we improve helping homeless veterans in finding job opportunities?

Mr. BERTONI. I am sorry. What was the first part of your question?

Mr. MICHAUD. As far as the reimbursement being burdensome and ways to streamline the process.

Mr. BERTONI. All right. The reimbursement aspects and the payment scheme was not part of our review. But in general, I would say personally we would like to see some empirical evidence as to what the effect is, what impact it would be having on providers, whether they are opting out of the program. That would be helpful to determine, you know, factual base that there is a problem indeed.

As far as going to sort of an up front payment versus reimbursement after the fact, I can understand where that would have a positive view amongst certainly the providers, why they would want that in terms of their planning and their ability basically to plan and figure out who they can serve going forward.

It does take some level of control away from the VA in terms of from an internal control standpoint. So, again, GAO would have to do some type of analysis to assess the soft points, the sticking points, how substantive they really were before we could come down. And, you know, what changes would be needed, I could not answer at this point.

As far as job opportunities, I think it is very important. We have OIF and OEF servicemembers coming back. Certainly in the Army, infantry members, many have very low levels of education, in need of job training. There are programs out there. I am not sure to the extent they are coordinated.

We are doing some analysis right now in terms of eligibility for those programs, who is eligible, who is not being deemed eligible, the programs that are the comprehensive menu of services that are out there, as well as participation in outcome rates.

And the bottom like, I think, from the Dole-Shalala Commission, we are trying to follow-up behind them and do some of our own analysis of that, there is no good data out there as to outcomes and long-term outcomes. So I think we need to do some work there.

And certainly the changing nature of the injuries coming back now, the traumatic brain injuries, PTSD, really a lot of value in up-

front screening, finding out what exactly these people need medically and then to get them set up for vocational rehabilitation training.

Mr. MICHAUD. Great. Thank you.

Mr. Miller.

Mr. MILLER. Mr. Bertoni, are you pretty satisfied with, or do you think the number of 200,000 is a relatively realistic number?

Mr. BERTONI. That is a tough one. I think we looked at what VA did, their point-in-time analysis. And given the unstable nature of the homeless population, we had no reason to question the reliability of that information.

Mr. MILLER. Is there another, more reliable method or recommendation that you could give VA to help them get that number?

Mr. BERTONI. We did not get behind the methodology or question the number, but we did walk through what they did to come to that number. I think we are satisfied that they used a reliable approach in terms of point-in-time analysis and going down to the local level to try to get those counts.

They did consult other groups that would have information like HUD. So I think while it is probably not a perfect figure, it is a reasonable figure.

Mr. MILLER. The VA Office of Inspector General (IG) recommended that the operational oversight authority and responsibility for the GPD Program be centralized at a national GPD Program office. Do you think this is a positive recommendation or do you have a view on it?

Mr. BERTONI. I do not have a specific view on that. I would just say in terms of oversight and accountability, whoever does it, there needs to be a sound program put in place with specific guidelines and criteria as to what guidelines have to be followed.

I do not think that is the case right now or it was not the case a year ago. So in terms of whether it is centralized or it is decentralized, I think there still needs to be an accountability program and oversight aspect to this program that I do not think has always been there.

Mr. MILLER. Ms. Beversdorf, you talked about reasonable measures of outcome and I had written down prior to that how do we grade success. Can you describe what you would call a reasonable measure of outcome?

Ms. BEVERSDORF. Our members report there is an evaluation system already. And I would defer to Ms. Spearman for more details on that.

But there certainly needs to be an evaluation of the outcomes. If a community-based organization submits a grant proposal with certain expected outcomes with respect to how many veterans they are hoping to treat, how many they are going to employ, how many they are going to provide services to, then those outcomes should be evaluated.

Obviously if our community-based organizations receive grant funding from the VA, they need to be responsible with respect to following through and performing the services they have indicated they would do. It is necessary to measure to see if they have accomplished the purposes they said they would do.

I will give you a comparison. The National Coalition for Homeless Veterans was recently awarded a grant from the VA to provide technical assistance to community-based organizations. We are required to provide quarterly reports indicating what services that we have provided to our members in the way of communications, training programs, educational programs, and publications.

Receipt of per diem payment is not a blank check. It requires responsiveness. Community-based organizations must show the funding they receive is spent in a way that will ultimately benefit the client.

Mr. MILLER. This is for both of you, Ms. Spearman and Ms. Beversdorf, would not the ultimate success be that the veteran is no longer homeless? That he or she is placed, and is off the addiction, the alcohol or whatever drug addiction that they may be suffering from? I know you have to check boxes, but would that not be the ultimate measure?

Ms. SPEARMAN. Definitely, yes. I mean, integration back in, working, those are things that I—I think we have all grown in this Grant and Per Diem Program since we have been a part of it for 10 years and the staff have as well. I think it may be time that we really could be more articulate about the goals that we are really looking to attain here because, as I said, it is very unrealistic when you think about what the steps are to take a person from, you know, the Ocala national Forest all the way to, you know, having a job, being retrained, being back into the community, and feeling good about that and, you know, no longer——

Mr. MILLER. Is that one of the things that you track?

Ms. SPEARMAN. We do all those things, but we do not do it with Grant and Per Diem money alone. And so our goal, in fact, in the testimony that I have written, we have shown that we have been a part of a pilot project, two pilot projects in Florida doing outcomes only. We only get paid if we deliver and it is a marvelous way to do business. It takes some time. It really takes sitting at the table, deciding what it is you want and how you are going to do those measures.

But we get paid one-twelfth of our grant as long as 80 percent of all of our—if every single individual, 80 percent of the individuals move forward toward independence. So it is a marvelous way to do business, but it is difficult. But it is definitely an option.

Mr. MILLER. Thank you for putting Pensacola in the mix. We are glad to hear that there are some things planned.

Again, between the two of you, is there more of a need for homeless veterans services in rural areas or urban areas because most of the focus appears to be on urban areas? I was interested that you picked Trenton of all places.

Ms. SPEARMAN. Yeah.

Mr. MILLER. Trenton is an extremely rural community. I was a Deputy Sheriff there when they only had one light in the county.

Ms. SPEARMAN. It still only has one light.

Mr. MILLER. Right there in downtown Trenton, the whole county had one red light. I know it is great everywhere, but where is the need the greatest?

Ms. SPEARMAN. Well, I will answer that first. Okay. I think there is a lot of need in the urban areas and they do congregate, a lot

do. But one of the reasons that we did the mobile service center, and that came from working with the VA staff in Veterans Integrated Services Network 8, is that everybody got together and sat at the table and talked about how were we going to outreach to the barrier islands around the Keys and into the national forest and how were we really going to go back in there. And that is how the mobile service center came about and then, you know, we developed the housing after that. But I do not know.

Ms. BEVERSDORF. I would echo. Sometimes, frankly, that is the frustration. The National Coalition for Homeless Veterans represents community-based organizations in 48 States. However, if you take a look at our annual report or a map of the United States, which indicates where these community-based organizations are, of course, there are fewer in Wyoming and North Dakota and some southern States as opposed to Florida or New York or California or Texas or Ohio.

And it is a dilemma. One of the things I am most proud of with respect to the direct services NCHV provides is we have a 1–800 toll free number. And we get as many as 300 calls a month, many of them from veterans who are either homeless already or at risk.

Someone will call and say, "Hi, I am so and so and I am homeless." He will also say, "Where can I go?" I immediately log onto our Web site and ask, "Where are you calling from?" "Well, Shreveport, Louisiana."

Because we have a list of all the community-based organizations, I really want to try and connect these individuals with community-based organizations that are located there. I may be lucky. I may be not.

So then I may have to become more creative. Well, let's see. How about faith-based organizations? I go through that list. How about perhaps veteran service organizations that might be able to help you? Have you contacted the Red Cross? How about other religious organizations? You are absolutely right, Mr. Miller. If there is not any community-based organization there, a place where they can go, they remain homeless and that's a problem. They are coming to these community-based organizations if they know where they are located. This is one of the reasons why NCHV has been trying to reach out to non-VA supported community-based organizations as well because there are places where VA funding has not been provided or, in some cases, these organizations do not know about Grant and Per Diem. Major issue.

Ms. SPEARMAN. And let me just say one more thing in terms of I think they are harder to reach in the rural areas. But I think the Vietnam era, that is where they have gone to to live. Those who have not, you know, stayed in the city. There is a good number.

So we have found many, many back in the forests. And you do not go back in there uninvited. And so you build rapport and it takes a very long time. But there are thousands back in the forests in Florida that we have identified and actually had an opportunity to interact with.

So they are harder to serve. They are harder to find. They are harder to bring into the system. They have been off the streets, in the woods. And so it is a mix, but I think the numbers are in the urban areas.

Mr. MILLER. Thank you.

Mr. MICHAUD. Thank you.

Mr. Salazar.

Mr. SALAZAR. Thank you, Mr. Chairman.

And, first of all, let me thank all 3 of you for the services that you provide for veterans.

Ms. Spearman, you talked a little bit about taking veterans in at risk, not really knowing whether you are going to get reimbursed or not. And, of course, veterans would be eligible for not only veterans' programs but probably eligible for Medicare, Medicaid, and other programs.

Do you think that maybe centralizing the system like, I think that is what you were getting to, Mr. Miller, maybe doing a pilot program to figure out if we would have a clearinghouse to see what programs each veteran was eligible for? Do you think that would help or is there already such a program?

Ms. SPEARMAN. I do not think there is anything specific like you mentioned. And I do not know that would be the answer. I just do not have an opinion on the centralization. I am sorry.

Mr. SALAZAR. Well, when I get questions in my office from many veterans, well, you know, I think I am eligible for this, I do not know whether I am, can you help me.

Ms. SPEARMAN. We have staff that do that. We have staff that have been trained by the VA, the VA benefits administrators. And I think that is one thing about the VA working more closely with the community is that a lot of community providers have no idea what a veteran is entitled to through the VA. And then those who have veterans in their programs who are not a part of the the Veterans Benefits Administration system, just have chosen not to, it just works both ways.

There is a lot of lack of communication about what a veteran is entitled to. And we spend a lot of time as Volunteers of America of Florida in the State, you know, trying to go to meetings and saying, you know, there are a lot of things that you are providing that veterans are eligible for. So I think a close working relationship on that, whether a screening or a centralized system.

I think the key is that we need to be able to respond a lot faster than we are responding. And I think that the community providers feel that most strongly and I think the VA typically just, you know, they do not see it as very positive, so it does not happen that way. So we are just much more proactive on an individual person by person because we are sitting there eye to eye and we are the provider.

We are the 24/7, you know, care service for that person or we are there in the community and available 24/7 and we have access to other linkages, so we spend more time believing in that system and how that——

Mr. SALAZAR. So the burden basically becomes yours to figure out what programs this individual is——

Ms. SPEARMAN. Yes.

Mr. SALAZAR [continuing]. Eligible for?

Ms. SPEARMAN. Yes.

Mr. SALAZAR. Mr. Bertoni, could you respond to that? Do you think that would help maybe expedite the process and be able to reach more veterans than what we are reaching right now?

Mr. BERTONI. If you had a single entity that essentially counseled folks on the menu and range of services that were available to them, the alternatives——

Mr. SALAZAR. Right.

Mr. BERTONI [continuing]. Is that the question? I suppose it would work. I do not know if it is necessary. Again, we have not done enough thinking about it to give you a definitive answer.

I do know at all 57 VA regional offices, there are veteran service organizations, VSOs, that are supposed to be doing just that, to sit down with veterans who are walking in. And I am sure they have a great handle on the range of services.

And I would hope that the veterans that are involved in the GPD Program are interfacing. And I think they would because there is a healthcare aspect there in terms of veterans' healthcare.

So if right now without a total restructuring, I think a good source would be for referral or a more aggressive role for the VSOs.

Mr. SALAZAR. But do not VSOs just work specifically with VA programs? But there are other Government programs such as Medicare, Medicaid, that, you know, your veterans are transitioning to and become eligible for that maybe some kind of a pilot program, Mr. Chairman, could be set up to where we could expedite this process. And I think it would make it much simpler and the risk would not fall upon the service providers.

Mr. BERTONI. One observation. I do believe the Social Security Administration and VA are beginning a similar effort to try to coordinate in terms of Social Security benefits versus VA benefits. I think it is very early on now. I do not know how far along it is. We are actually thinking about looking at that.

Mr. SALAZAR. That is all I have, Mr. Chairman. Thank you.

Thank you.

Mr. MICHAUD. Thank you very much.

Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

This challenge reminds me of the challenge that we were facing several years ago with regard to TRICARE payments to medical providers and probably some of my provider friends are probably telling me that they are still facing, but I think it is substantially improved, which was one of my doctor friends back home that managed a very large practice said that the problem with TRICARE payments is that they were low, they were slow, it is complicated.

And you could handle one of those as a provider. You cannot handle all 3 of them together, where if the payment is low, it is slow getting to you and the paperwork burden is complicated to finally get the low payment to you in a slow manner. Help me, if you would, because this is an area that I do not know a lot about.

It seems to me that there are like 5 options out there. One is to do nothing and just going with the current reimbursement rate which I do not think anyone would be satisfied with that.

The second one would be to increase the per diem rate, but basically keep the system like it is.

The third one would be to go to a cost of service option probably with some kind of geographical variation that people would have to say here is what our actual costs were to get reimbursed.

A fourth would be to have some kind of grant program that would pay for, I assume, some kind of annual grant to provider services that may or may not allow for some beds being empty.

And the fifth one is some kind of program of permanent housing, supporting homeless veterans in permanent housing.

Are those the basic 5 options we are looking at?

Ms. SPEARMAN. I will respond to that. I think that is definitely in the mix. I think there are some others that could be considered.

Mr. SNYDER. What are those?

Ms. SPEARMAN. One would be doing a housing per diem base; what it really does cost to do housing management and place people in housing and house them. And then maybe some service overlays. I know geographical consideration is important, but also the level of service.

There are providers that are excellent providers that can only do a minimal amount of services, whereas Volunteers of America of Florida may be able to do, you know, clinical treatment, substance abuse treatment, a lot of other things that VA is not able to, you know, keep up with. And we could do a lot more levels of service.

So obviously with services come dollars. So there could be levels of service of per diem on top of that. And they are, you know, an outcome base where you would have like maybe a grant based on cost and then you would do it with performance.

So there are some others. There are some others that are used by HUD that are used by other programs that some of us are familiar with. But you hit on some. I hope we will not pick the one to do nothing. I hope that we will move forward.

Mr. SNYDER. I appreciate what you are saying about the different levels of services that different organizations choose to provide or can provide or have the capability to provide and some of that is going to be geographic because some areas have more services available than others.

But when it is based on cost, what is the incentive for the organization to keep costs down? Tell me how that works as you see it.

Ms. SPEARMAN. Well, you know, you are going to have to operate within your cost if you do the budget and you are monitored on the budget to keep your costs within. I do think there should be, you know, a cap on, you know, what it is, whatever you presented in your budget.

I think a per diem for a larger organization, the incentive is that you have the flexibility to spread some of your costs and get some money to the bottom line. In terms of a business, it is an on-going concern to make sure that you are putting more money back into the program.

So I mean, I just think you are going to be bringing in other dollars regardless from other—I mean, I do not think that the grant per diem is going to pay for all that needs to be done for homeless veterans to get them where they need to go. So I mean, I do not know. Maybe I did not answer the question.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Once again, I would like to thank the 3 panelists for your testimony this morning and look forward to working with you as we move forward on this issue. So thank you very much.

Ms. SPEARMAN. Thank you.

Mr. MICHAUD. I would like to have the second panel come forward. George Basher who is Chair of the United States Department of Veterans Affairs Advisory Committee for Homeless Veterans. He is also Director of the New York State Division of Veterans Affairs.

Peter Dougherty who is the Director of Homeless Veterans Program at the Department of Veterans Affairs who is accompanied by Paul Smits who is Associate Chief Consultant for Homeless and Residential Rehabilitation at the Department of Veterans Affairs.

I would like to welcome this next panel and we will start off with Mr. Basher.

STATEMENTS OF GEORGE BASHER, CHAIR, ADVISORY COMMITTEE ON HOMELESS VETERANS, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND DIRECTOR, NEW YORK STATE DIVISION OF VETERANS' AFFAIRS; AND PETE DOUGHERTY, DIRECTOR, HOMELESS VETERANS PROGRAMS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PAUL SMITS, DIRECTOR, HOMELESS AND RESIDENTIAL REHABILITATION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF GEORGE BASHER

Mr. BASHER. Chairman Michaud and Members of the Subcommittee, I am pleased to be here today to discuss the VA Grant and Per Diem Program serving homeless veterans. I thank you for the invitation to testify before the Subcommittee and discuss this worthy program.

I have had the honor of serving as the Director of the New York State Division of Veterans Affairs for the past 10 years and also currently serve as the Chair of the Department of Veterans Affairs Advisory Committee on Homeless Veterans.

In both of these roles, I have had the opportunity to witness not only the benefits of this program to those veterans who need a hand getting back on their feet, but also the challenges it brings to the provider community.

Recent estimates by the National Alliance to End Homelessness place the number of homeless individuals in the United States at 750,000. VA estimates the number of homeless veterans to be approximately 180 to 200,000, making homeless veterans one-quarter of the entire homeless population.

Established by Congress in 1992, the Grant and Per Diem Program has provided nearly 10,000 transitional beds for homeless veterans through the efforts of over 300 community-based providers. These community and faith-based organizations provide shelter, food, and supportive services to homeless veterans for up to 2 years for a per diem currently set at a maximum of $31.30 a day.

Originally designed to meet the needs of Vietnam era veterans, I believe it is time to revisit the Grant and Per Diem Program in light of the need to also serve the veterans of the current conflict as well as those older veterans.

VA estimates they have already seen over 1,500 OEF/OIF veterans in various settings with several hundred referred to GPD providers for assistance.

The VA Advisory Committee on Homeless Veterans in its recent report discussed concerns about Grant and Per Diem. Specifically, first, the VA Grant and Per Diem Program uses a process to reimburse providers designed like the system VA uses to reimburse State Governments for the State Home Program. The Advisory Committee is concerned that this capped process discourages providers in high-cost areas from even applying.

The current $31.30 rate is based in law on the rate paid to State Home programs. There is no basis, in fact, for the $31.30 rate in the State Home Program and no defined rationale for determining that figure.

Additionally, the current process does not allow the use of other Federal funds without offset by VA. While the State Home Program rules were recently changed to allow this, the restriction of offsets still applies to Grant and Per Diem programs.

Second, the accounting process required for reimbursement is a burden on small community-based providers. Asking this group to meet the same level of expertise as State Governments with larger accounting staff is unreasonable and discourages participation.

Additionally, recent audits of some providers have led to allegations of significant overpayments sometimes years after the fact based on differing interpretations of allowable expenses.

Parenthetically this devolves from that idea that the contract oversight and inspections are done by VA medical center staff, the liaisons, and I think we have over 120 different people inspecting 300 different programs. The notion that this is all being done uniformly, fairly, and accurately is probably silly when you stop and think about it.

Third, community-based Grant and Per Diem providers frequently use other Federal programs to augment the services provided to veterans. Current Grant and Per Diem regulations do not allow these funds to be used as a match for VA programs often discouraging participation.

Conversely, other Federal programs do allow VA funds to be used as a match creating a disincentive to participate in VA programs.

The Advisory Committee recommended the per diem be revised to allow payments to be related to service costs rather than a capped rate allowing higher cost areas where homeless veterans are often numerous to participate.

The Advisory Committee also recommended allowing other Federal funds to be used as a match to VA funds and also allow other Federal funds to be used without offset.

Incorporated in these recommendations is implied the recommendation that the current burdensome accounting process would be scrapped and replaced by a simpler mechanism to provide reimbursement and protect the taxpayers' interest. Paying a fee-for-services provided meets the needs of both the veteran client and

the providers without placing an undue burden on either the providers or the Government.

Beyond adjustments to the existing Grant and Per Diem Program, other related concerns need to be addressed. Historically most homeless and housing services have been provided by the U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services.

VA housing initiatives have focused almost exclusively on transitional housing reasoning that traditional VA programs coupled with Grant and Per Diem support services were all that was needed to return homeless veterans to a permanent housing environment.

With 20 years' experience in homeless veterans programs, we now know this is a simplistic view. Veterans with a comorbidity of substance abuse and behavioral health disorders are frequently incapable of making the jump from transitional housing and programs to self-sufficiency. Experience has again taught that supportive permanent housing is often the most effective and economical way to have these individuals reenter the mainstream.

The existing HUD–Veterans Affairs Supportive Housing (HUD–VASH) Program providing Section 8 vouchers is woefully inadequate due to a lack of specific appropriations for the program by HUD. The Advisory Committee has recommended to VA that HUD–VASH be expanded and further that VA look for opportunities to partner with HUD and other agencies to find innovative ways to bring permanent housing and supportive services to veterans.

Consideration should be given to site-based Section 8 vouchers as a way to provide those services on an ongoing basis by community-based providers.

Success of programs such as New York City's New York, New York 3 initiative have demonstrated an integrated approach like this can provide positive results at an affordable cost.

The still ongoing Capital Asset Realignment for Enhanced Services, CARES, process VA is using to identify capital requirements for the next 20 years has identified a significant amount of surplus VA land and facilities. One of the Advisory Committee recommendations was to have VA make reuse of this land for veteran housing a priority.

VA officials contend the existing Enhanced Use Lease Program is adequate to meet that need, but experience shows the Enhanced Use Lease to be a time-consuming, cumbersome process fraught with opportunity for delay and lost opportunities.

The Department of Defense Base Realignment and Closure procedure, BRAC, is much more efficient in terms of making reuse opportunities a reality in a reasonable period of time.

There is a growing concern regarding women veterans. With women now making up nearly 20 percent of today's military, VA's programs are being accessed by an increasing number of women veterans including programs for homeless veterans.

There are unique challenges in this shift. Most VA programs were designed when the military was nearly exclusively male, necessitating changes by Veterans Healthcare Administration to facilities and procedures that are ongoing even today.

Transitional housing programs for women veterans are rare given the relatively low numbers involved and the economies of scale needed to provide services. Issues of safety and appropriateness of facilities likewise challenge traditional homeless service providers.

Another consideration is the authority of VA to only care for the veteran. Children who have no other parent to care for them also often accompany the increasing number of women veterans. Accessing VA services by these veterans means leaving children with other relatives or nonfamily caregivers, a difficult choice that often leads to walking away from VA care and looking for help elsewhere.

VA should explore ways to cope with the changing demographics of the military and adjust accordingly either in partnership with other agencies or through programmatic changes of its own.

The VA Grant and Per Diem Program has provided a valuable service to homeless veterans over the past 15 years. Adjusting the program in light of experience is appropriate. Creating new policy to meet the needs of returning veterans from the current conflict is a necessity.

Mr. Chairman, this concludes my formal remarks. I appreciate the opportunity to present my views and am prepared to answer any questions you or Members of the Subcommittee may have.

Thank you.

Mr. MICHAUD. Thank you very much.

[The prepared statement of Mr. Basher appears on p. 44.]

Mr. MICHAUD. Mr. Dougherty.

STATEMENT OF PETE DOUGHERTY

Mr. DOUGHERTY. Thank you, Mr. Chairman, Members of the Subcommittee.

VA has the largest and most comprehensive collaboration for homeless veterans in the country. We have more than 300 community and faith-based organizations, State and local and tribal Governments who work with us in this program.

I am very pleased to be joined today with Mr. Paul Smits who is the Director of Homeless and Residential Rehabilitation Program for the Veterans Health Administration.

The effort to engage community and faith-based providers began with this Committee with the passage of H.R. 5400, the "Homeless Veterans Comprehensive Service Act," later signed by President George Herbert Walker Bush on November 10th, 1992.

VA has offered funding under this proposal or under this law since 1994 and has awarded new funding each year since then. We now have awarded funding to more than 400 programs and have authorized more than 11,000 transitional housing beds.

There are more than 8,000 transitional beds in service today and the remaining ones are coming on once the rehabilitation or the acquisition of property and repairs and renovations have been completed. And we will soon announce that we will add about another 900 to 1,000 new beds to those that have been previously approved.

We continue to offer new funding because we have great faith in the ability of the many community providers to provide high-quality services to veterans. Our goal based upon this Congress' man-

date is to end chronic homelessness among veterans. We have made good strides in achieving that goal. We simply would not be able to do so without our community-based partners.

There was some discussion earlier on and I want to remind the Committee that VA unlike any other agency that is out there, both private and public, monitor and evaluate every veteran who comes to a homeless specific program.

Since 1987 when VA began homeless specific programs, we have identified and provided services to about 400,000 veterans who we have identified as being homeless. We have a system of accountability because ultimately it does not matter as much to us about the money as to the outcome for the veteran. Just as we do in every other healthcare program, if the veteran needs the services to get better, we are going to use the money to get the veteran to a position where they get well.

In this case, we do have a capitation on our funding, but we work in a very close partnership. What the Committee Members were asking about before, is we not only have great community providers that we work with, but we have a lot of VA dedicated staff who work in community programs.

Some of them are there on a daily basis working hand in glove. Some of the questions about the accessibility and availability of benefits and other services are responded to because we have people on both sides (VA and community) who can answer those questions.

We have performance measures that we have implemented in the last few years that we think help. If you are identified as a homeless veteran, we want to make sure you get a primary healthcare visit within 30 days and you get follow-up specialty care within 60 days.

When we first started it, there was a lot of groaning on our side about putting that requirement on us. We are meeting that performance measure.

We also have many of the providers that we are working with. Ms. Spearman and others have very significant, substantial programs. She has a lot of other resources because her organization has been very effective at doing that.

Some of the smaller programs do not have that. One of the good things that the Department did this past year is added 30 substance abuse counselors who work on-site in community-based programs.

We are getting an increasing number of community programs where dental care services to these veterans are being provided and we now have reentry specialists working with veterans returning from prison.

We are in the process of completing hiring at least one person in each network to work with the criminal justice system to make sure that veterans who are coming out of the criminal justice system do not show up in the ranks of the homeless, that they get their benefits and get on with their lives and do not become homeless in the meantime.

We think all of these things are having some increasingly positive results of what is happening. We closely monitor and we aggressively reach out to all veterans who are homeless, but we

would like to make note of those who are coming back from Iraq and Afghanistan. It gets a lot of attention. We wanted to give you an update today.

During the past 3 years, we have been specifically monitoring veterans who have returned from Iraq and Afghanistan who have shown up at the ranks of the homeless. More than 1,500 of those veterans that we have seen in outreach have served in those theaters of war and more than 400 of those have been in a homeless specific program.

What that tells you in part is that some of the veterans that we are seeing in the outreach are not what you and I might consider to be literally homeless today. They may, in fact, have a full-time job, but they may still be going to a soup kitchen to get something to eat. They may have relationship problems with family and others that are putting them at risk.

It is also important to know, because sometimes people wonder, "Is this Government sort of turning a blind eye or is this Department turning a blind eye to that problem?" The point is it is not just our staff and our people out there seeking them out. It is the community-based organizations who were at this table a few moments ago and State and county veteran service officers. All those people are making contact with us and doing outreach.

I can tell you on a positive side, although people say is it not tragic, what we are finding is those veterans who are coming back from Iraq and Afghanistan who are coming in and getting treatment are doing, well. In fact, slightly better than other homeless veterans both in getting back into permanent housing and into employment.

As the Committee knows, we are limited as to how much we can provide in reimbursement for support and that is that $31.30 a day for housing under the Grant and Per Diem Program.

As you have heard today, and we understand there is a lot of concern among providers about that amount of payment, I think it may be a little bit illustrative and informative for the Committee to have you understand the process that goes on.

When a veteran comes into a community-based program, we are supposed to have 3 days in which to determine their eligibility to be in that program. They provide services to that veteran. They provide to us a list with name, date, and Social Security number by bed day of care for the veteran who is in the program. We verify the information and then we reimburse after the fact.

One of the things that does make us different than most Federal grant agencies is when you get a grant from them to do this type of service, you get to draw on a monthly basis. In our case, you have to wait until we get verification, until we can assess, make sure the information is correct, and we pay you after the fact.

That creates problems because many of these folks do not have a lot of income, if you will, to float. Most other Federal programs do it differently. They let you draw in advance during the month you are actually doing the services.

One of the questions that we get and one of the things you heard is sort of what is called the flat rate concept. The flat rate concept, we are sometimes asked why we do not have it? The reason is per diem payments are considered to be a grant under the law. And,

therefore, we must comply with the Office of Management and Budget (OMB) circulars.

VA guidance requires us to determine the allowable and unallowable cost based on the OMB circulars. It is our understanding that a flat rate of a straight payment. It would only be feasible if we had specific statutory authority and a waiver of the circulars from OMB.

Mr. Basher mentioned a moment ago, and I would like to remind the Committee under the HUD–VASH Program, which we consider to be a very successful initiative where we provide case management services and HUD provides money for permanent housing, that you have already passed on the House side in the appropriations bill that would include 1,000 additional HUD–VASH vouchers. The Senate has actually put in its bill $75 million which we believe would create more than 6,000 new HUD–VASH vouchers.

For the first time in many, many years, it looks like there will be authority for new permanent housing which is the top unmet need according to our Advisory Committee on Homeless Veterans, as well has our community partners for more than a decade.

VA along with our partners have done a good job. I think the quality of care veterans get in most of these programs are very good. We do understand the frustration of the payment system. We are trying to do the best we can with the process that we have.

Mr. Chairman, this would conclude my formal statement and certainly we would be happy to answer any questions you and the Subcommittee have.

[The prepared statement of Mr. Dougherty appears on p. 46.]

Mr. MICHAUD. I would like to thank both of you gentlemen once again for your testimony this morning.

Is there a change that we could make that would maintain or improve the oversight of funds while reducing the paperwork burden to providers and provide flexibility?

I mean, everyone has said this morning that it is slow, that it is cumbersome. There must be a way that it could be streamlined and still have the accountability that we need to make it a worthwhile program.

Mr. DOUGHERTY. Mr. Chairman, I think that, yes, there probably is. We are already tied, if you will, to the State Home reimbursement rate. If we use that as a straight payment system and we then said to the recipient of the grant, the recipient of the payment what is it you would do specifically with that amount of money, then we would simply go back in and we would audit for that purpose of those expenditures.

Right now we have to look at everything the organization does. The bigger and the more complex the organization is, the harder it is.

I think the other thing, as was mentioned by the Committee Members as well in questioning, is that also incentivizes me to do more. At $31.30 a day, given the kinds of services that we require, it is a very modest amount of money. But I think if we could define for the providers that this is the amount that is being provided for you to do certain things for us. If you may need more employment and you could go to the Department of Labor or your State job services and they give you funding to provide an employment spe-

cialist in your program, it is good for the veteran and, if we were not paying for it anyhow, so what?

We need better housing outcomes, it is the most critical problem we face in the homeless program. If you come through a good program and you may be too disabled to go back into independent living and go out and get a job. If you could get into good, stable housing, we would get you out of the grant program. We would not keep you there without an expectation of getting a better outcome.

So if you could go to your local continuum of care and get a housing specialist to work part time with you and your program, if VA were not funding it under our grant, the veteran would get a better housing outcome, good for the veteran, good for the program.

So I think there is a way to do that, but it would require some change in law.

Mr. MICHAUD. Great.

Following up on that, when you look at the services that the providers provide depending on which provider it is, they provide a variety of different types of service, is there a minimum standard that all Grant and Per Diem providers must follow and, if so, what is that?

Mr. DOUGHERTY. Yes, there are. In the application that they file, there are minimum things that we expect you to do be able to provide.

Now, as Ms. Spearman mentioned this a few moments ago. The level of services that may be offered is one of the things when Congress created this program. The program addressed the urban and rural conditions. In Los Angeles, California, we have 20-some programs in Los Angeles County. They have some specialty services, if you will, that they provide.

In the more rural areas, you may be a more comprehensive sort of service because you may not have just expertise in substance abuse treatment or you may not have more expertise in mental health services. And so you may be more comprehensive.

We do expect you to both provide a safe, decent environment in which the veteran is to live. You are to provide case management. You are to work on objectives of improving your daily living. You are supposed to reduce your healthcare dependency. In other words, you are to get us connected with that veteran for healthcare or to get that veteran to other healthcare services.

You are to work on improvements in your living skills. You are to do other things related to improving their health condition and reduce substance abuse and other kinds of destructive behaviors.

We do have minimum requirements that apply to everybody, but many programs have specialties that they provide. And the grant process is designed to meet the local need as it is in your community to address the needs of homeless veterans.

Mr. MICHAUD. Mr. Miller.

Mr. MILLER. Mr. Basher, are the risk factors for veterans from the all-volunteer Army any different from those that were part of the draft era?

Mr. BASHER. In my opinion, yes, they are. The thing that I have observed over that period of time is that if you look at the Vietnam era veterans, they were largely a component of draftees overseen

by a cadre of regular military. Today you have all volunteers. And the big difference is age.

When I came home from Vietnam, I was a unit commander in Vietnam and I was 21 years old. When I came home, I was the old guy. You know, most of the people in my unit were 17, 18, and 19 years old.

Today I think you will find if you look at the 10th Mountain Division in New York, the average age of the second combat brigade up there is probably about 25 to 26 years old. They tend more to be married. They tend to have more dependents.

And I think that as we drill down and are starting to learn, the very nature of this conflict, particularly in Iraq, is very, very different than any other war we have ever fought. And it is creating some new challenges and I think also some new opportunities for us. So, yes, they are very different.

The incidence of Post Traumatic Stress Disorder, incidence of Traumatic Brain Injury clearly are already indicated to be higher than they have in past conflicts. Those require some different things. You know, when you stop and think about it, treating a veteran with a condition like PTSD or treating Traumatic Brain Injury and, again, VA by statute is required to treat the veteran and not the family, but everybody that is involved suffers with that kind of condition whether it is PTSD or TBI.

The absurd extreme example would be, you know, the VA is only allowed to talk to the Alzheimer's patient, not the family that is with them. So, you know, we need to look at what is to leverage all these services and maybe adapt and grow to meet those changing demographics.

Mr. MILLER. What about other factors like alcohol or drug abuse?

Mr. BASHER. We are seeing a fair amount of that in New York. I mean, the only real on-the-ground experience I have is the 10th Mountain and 10th Mountain, the second combat brigade is the most deployed unit in this country.

If you signed on to that group in the year 2000, you have already completed your fourth combat tour since 9/11. If you are a promotion hound, you are on your fifth or sixth. So if you do the math with the time and rotations, you know what the level of time that these people have when they return home.

So there is some stress on those soldiers and as they return, you know, it does not manifest itself immediately, but I think over time, you start seeing challenges and family challenges and readjustment. And the military is trying to cope with this too. But we definitely see an increase in both substance abuse and also alcoholism coming back from those deployed units.

Mr. MILLER. Mr. Dougherty.

Mr. DOUGHERTY. Yes. Mr. Miller, we can tell you that the level of homelessness relates very specifically to the military standard. As Mr. Basher indicated, when you look at the late Vietnam War period and the immediate post Vietnam War period, that is the biggest bulge, if you will, in the list.

We do get concerned when the military standard changes. Dr. Bob Rosenheck who does all the program monitoring and evaluation of all of VA's homeless programs will tell you that the incidence of homelessness actually went down, have gone down rather

dramatically when we went to the all volunteer Army. When you look at the late eighties and early nineties, the incidence of homelessness among veterans seemed to have changed. So there is a relationship.

Regarding the recently returning veterans, we can tell you that among those who have shown up in the ranks of the homeless there is a significant difference in that the level of substance abuse which is much less among this group than all homeless veterans and the level of combat and mental illness are related.

We have a much higher ratio of mental illness among the recently returning veterans from Iraq and Afghanistan than we do in all homeless programs, about 45 percent in all homeless programs, closer to 70 percent in those who have come back from Iraq and Afghanistan.

One of the differences among all veterans who we see in homeless programs, about 20 percent have been combat veterans or what you and I would consider to be combat veterans, and those coming back from Iraq and Afghanistan is closer to 70 percent.

I had a conversation before with the gentleman from GAO. We were talking about this issue. And, you know, truck convoys are not necessarily combat-related duty, but certainly none of us who know anything about what is going on would assume that riding convoy patrols is a very safe mission in Iraq and Afghanistan. It may have been in many of our previous wars, but it is not in this one.

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

I just have one question that I would like both Mr. Basher and Mr. Dougherty to respond to, if you would.

In fact, Mr. Dougherty, you mentioned in your written statement about the problem of incarcerated veterans and when they are released.

Would you both talk about this issue of incarcerated veterans and where we are at with that and, you know, you always have perspectives? So if you each take a couple of minutes.

Mr. DOUGHERTY. I can talk about it in a broad sense. And Mr. Basher, because he is in a State that has done a very good job with it, can even talk about it in more specifics.

This Congress a few years ago asked VA and the Department of Labor to work on a pilot initiative which we have been doing for the last few years. The initial results of that are rather positive.

About 40 percent of the veterans that we see in homeless programs have been previously incarcerated which is not surprising because many people who end up in the incarcerated ranks are substance abusers and have mental illness problems. And many of them when they come out without a good discharge planning process show up in homeless programs. It is just sort of a normal happenstance.

We have been working with the Department of Labor on pilots authorized by the Congress. We are actually in the process of finishing a report. We think that what we will be able to show you in our report is that there will be a significant reduction among veterans going back into incarceration when they have been engaged with community providers prior to discharge, benefits assess-

ments have been made, and discharge planning established to get the appropriate healthcare they need if eligible when they come out.

I think without sort of prejudging what our final report will say, I can tell you clearly it will be at least half of what the normal re-incarceration rate is by using this kind of intervention.

The Volunteers of America in Kentucky, which is one of the pilot sites, they believe that it saved re-incarceration costs in the State of Kentucky by more than what it costs the entire initiative to cost the Federal Government for the 7 pilots across the country. It has a very positive relationship.

I am the Department's representative at the U.S. Interagency Council on the Homelessness, the senior policy group; and we know homelessness, one of the biggest risk factors of homelessness is having parents who are homeless and parents who are incarcerated.

And so obviously even though it does not necessarily end the problem for us right away, we think that by addressing this issue better in the future, we may, in fact, help society down the line.

Mr. SNYDER. Thank you.

Mr. Basher.

Mr. BASHER. Yeah. In New York, what we did about 7 years ago was we started definitely identifying veterans who were entering the State prison system and we currently have about 60,000 inmates. And out of that number with an average sentence length of a little over 3½ years, we graduate about 1,000 veterans into society at the end of every year.

And we discovered early on that nobody has got enough money to do everything, so the VA cannot take this on by themselves. The State of New York Prison System certain cannot. Our parole system cannot. But we have worked together and figured out, first of all, how to get around some of the programmatic things.

New York has 2 VA networks, Network 2, Network 3, and their geography and their chain of command is very different than how our State Prison System works. Most of our offenders come from the major metropolitan areas, the largest being the New York City area. And if you have been incarcerated, you wind up serving your sentence primarily up in the Adirondacks, some place far, far, far away from home in a different VA network.

As you get closer to your release date, you get moved closer to home. But what we have managed to do is seamlessly follow these people and when they get within 6 months of release, our parole people start working on their release plan.

And we send a counselor, one of our State counselors in because we are not constrained by the same rules as VA and make sure that we know if somebody has got eligibility for comp to be turned back on when they get out. We make sure that happens seamlessly.

We make sure that if they do not have family to go back to and a place to live that they get handed off to the VA, to the system, and work into the dom system or whatever appropriate program there is.

We think we have managed to reduce the recidivism for that group of people to under 40 percent which we think is more than

cost effective. It has taken us a long time to work out all the kinks, but now it is almost automatic.

Mr. SNYDER. Thank you.

Thank you, Mr. Chairman.

Mr. MICHAUD. Just one last question to follow-up on Mr. Miller's question about dealing with homelessness for veterans in rural areas and the programs that are available. Unfortunately in some instances, service providers may not be able to reach some of these rural veterans, which brings up the use of faith-based organizations.

My question is, do you work very closely with the Red Cross in rural areas to see if they could help with some of these problems?

Mr. DOUGHERTY. We work very closely with a whole host of agencies across the country and rural areas. Mr. Miller talked about being a Deputy Sheriff. I was a County Magistrate in West Virginia. And, those kinds of relationships are where it does not matter who you are and what you do.

The problem comes forward in little towns and little communities in ways that big communities have the bureaucracy to deal with; in little communities, somebody just calls somebody who calls somebody.

We work with a whole variety of partners. We have been out to the White House Faith-Based and Community Initiatives Program telling them about the availability of healthcare and services. We meet with the State Directors on a regular basis, the County Veteran Service Officers across the country. We have met with the Red Cross and Volunteers of America and national organizations like that, Salvation Army, to make those kind of relationships.

In this day and age, even in most rural communities, there is a pretty good understanding, I think, that there is some help. It is really a question of access. And that is why one of the reasons that what we have done in the last few years is tried to make sure that, for example, on tribal lands, we have put some targeting in our funding to make sure that tribal lands, which are historically pretty remote and rural, have some opportunity to get funding or enhanced opportunities to get funding so that programs can be there.

The other good thing about this program is it does not have a minimum and a maximum. In other words, some Federal programs say you have to have 50 units before you can get funded. We have programs as small as 6. Those are the kinds of programs that meet local needs.

I use the terminology a lot that there is an intensity of need and the intensity of need is, different where there are a lot more homeless veterans in New York City than in an upstate New York. But if you have that problem in your upstate New York location, you also want to have an opportunity to get some reasonable way to address it for the veterans who are in your community. And so I think we have the opportunity to do that.

Mr. BASHER. Just to use New York as an example, our Division of Veterans Affairs is in 60 different locations in New York State. And while we have 11 offices in New York City, we also have an office in Malone. So, you know, it is local knowledge on the grounds of who the providers are and generally they have a pretty good

sense of who the customers are, too, when the homeless folks show up.

And as Mr. Dougherty pointed out, big programs are in the urban area, but Glens Falls, New York, has a little 7-bed house that does not have any empty beds. So, you know, the need is up there. And it is almost an if you build it, they will come situation.

Mr. DOUGHERTY. Also, Mr. Chairman, many communities come to us because they do stand downs. And the Interagency Council on the Homeless now does a thing called Project Connect. And the largest one in the country last year was Libby, Montana, which is not exactly the biggest metropolis on the face of the Earth. Over 1,000 veterans and family members of veterans came to that event. And, you know, it did not just attract you purely because you are homeless, but a lot of veterans who needed services came to that event.

And so there are increasing opportunities. We support those opportunities. We provide a lot of staff both from the Benefits Administration and the Health Administration to help make sure that healthcare and benefits are there and in some cares are provided on-site.

Mr. MICHAUD. Once again, I would like to thank this panel and the first panel very much for your testimony today and look forward to working with you as we move forward on this very important issue.

So, once again, thank you. This hearing is adjourned.

[Whereupon, at 11:29 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

Today, we will examine the Department of Veterans Affairs Grant and Per Diem Program for homeless veterans.

On any given night, there are approximately 200,000 homeless veterans on the streets in America. The majority of these veterans served in Vietnam, 96 percent are male and about 45 percent suffer from some mental illness.

VA has many programs to help homeless veterans—including the Grant and Per Diem Program. VA needs to continually evaluate these programs to ensure that veterans are getting the services that they need and that provider organizations can effectively provide these services.

For example, while the vast majority of homeless veterans are male, female veterans are the fastest growing segment of this population.

Women homeless veterans face similar challenges to their male counterparts, but they are very likely to have experienced serious trauma including abuse or rape and a significant number also have children to support. VA programs must be flexible to meet this new challenge.

I believe that VA should make sure that they give Community Based Organizations the tools they need to provide comprehensive services to our homeless veterans.

The way in which the Grant and Per Diem program is currently structured sometimes makes this difficult—particularly for providers in high cost areas.

It is my belief that the goal of VA homeless programs should be to not only provide veterans with a bed for the night and a meal—but to provide them with the resources that they need to attain permanent housing, a steady job and a renewed sense of self-worth.

Today, I hope that we will learn what VA is doing to provide services to homeless veterans to help them break out of this cycle. We will hear about the Grant and Per Diem Program—both what is working and ways that it can be.

One homeless veteran is one too many. This is a problem that we can solve by working together.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member

Thank you Mr. Chairman.

This year marks the 20th Anniversary of VA's programs to provide specialized services for homeless veterans. VA's first homeless program began in 1987, with the enactment of Public Law 100–6. This law provided VA with $5 million to support care for veterans in community-based and domiciliary facilities.

Since that time, VA's homeless programs have expanded and grown significantly. VA budgets almost $2 billion to treat and assist homeless veterans and administers over nine specialized homeless programs that integrate housing and mental health and substance abuse counseling.

Although it remains difficult to obtain an accurate count of the number of homeless veterans, there are indications that we are making good progress in helping to reintegrate homeless veterans into stable community environments and lead productive and sober lives.

Still, there are far too many veterans out on the streets. On any given night in my home State of Florida alone it is estimated that there are 17,000 homeless veterans.

Critical to ending homelessness among veterans is being able to identify vulnerable service men and women early and make sure that these veterans are aware

and have immediate access to the services and benefits available through VA and in coordination with other Federal agencies.

With the increasing number of returning veterans from the conflicts in Iraq and Afghanistan, the development of innovative services to help especially at risk veterans is extremely important.

Another area of great concern is addressing the needs of women veterans and increasing the availability of facilities that are able to provide appropriate accommodations for women and women veterans with children.

Today, we will review VA's Homeless Providers Grant and Per Diem Program (HGPD).

The Grant and Per Diem program is considered to be a very successful collaboration between VA and non-profit and faith-based organizations.

However, in a 2006 report that we requested from GAO, they found that improved communications and follow-up could further enhance the program. GAO reported that liaisons responsible for coordinating with local providers sometimes found it hard to assist due to large caseloads and other administrative tasks within their duties and a VA identified need for an additional 9,600 beds.

Our Committee has always worked in a bipartisan manner to strengthen health care, housing, employment training, and other services to assist at risk veterans.

I look forward to continuing to work with Chairman Michaud to provide aggressive oversight of VA's implementation of homeless programs and establish greater Federal collaboration between VA, HUD, and HHS to coordinate efforts to assist homeless veterans.

I would like to welcome all of our witnesses. Especially I would like to thank Kathryn Spearman with the Volunteers of America, Florida for participating in our hearing this morning. I am grateful for your dedication and many years of work to provide services to assist homeless veterans in my home State of Florida.

Thank you Mr. Chairman, I yield back the balance of my time.

Prepared Statement of Cheryl Beversdorf, RN, MHS, MA,
President and Chief Executive Officer,
National Coalition for Homeless Veterans

Introduction

The National Coalition for Homeless Veterans (NCHV) appreciates the opportunity to submit testimony to the Health Subcommittee of the House Committee on Veterans' Affairs regarding the VA Grant and Per diem Program. Established in 1990, NCHV is a not for profit organization with the mission of ending homelessness among veterans by shaping public policy, promoting collaboration, and building the capacity of service providers. NCHV is the ***only*** national organization wholly dedicated to helping end homelessness among America's veterans.

NCHV was founded by a group of community-based homeless veteran service providers who sought to educate the public about the extraordinarily high percentage of veterans among the homeless population and to place the needs of homeless veterans on the national public policy agenda. The founders, all former members of the military, were concerned that neither the public nor policy makers understood either the unique reasons for homelessness among veterans or appreciated the reality that so many veterans were overlooked and underserved during their periods of personal crisis.

In the years since its founding, NCHV's membership has grown to nearly 280 organizations in 48 states and the District of Columbia. As a network, NCHV members provide the full continuum of care to homeless veterans and their families, including emergency shelter, food and clothing, primary health care, addiction and mental health services, employment supports, educational assistance, legal aid and transitional housing.

Homelessness Among Veterans

The VA reports homeless veterans are mostly males (3 percent are females) and the vast majority are single, although service providers are reporting an increased number of veterans with children seeking their assistance. About half of all homeless veterans have a mental illness and more than two thirds suffer from alcohol or other substance abuse problems. Nearly 40 percent have both psychiatric and substance abuse disorders. The VA reports the majority of women in homeless veteran programs have serious trauma histories, some life-threatening, and many of these women have been raped and reported physical harassment while in the military.

According to the VA Northeast Program Evaluation Center (NEPEC), male veterans are 1.3 times more likely to become homeless than their non-veteran counterparts, and female veterans are 3.6 times more likely to become homeless than their non-veteran counterparts. Like their non-veteran counterparts, veterans are at high risk of homelessness due to extremely low or no livable income, extreme shortage of affordable housing, and limited access to health care. But these factors combined with their military service put them at even greater risk of homelessness.

Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with Post Traumatic Stress Disorder, also known as PTSD, or have addictions acquired during or after their military service. NEPEC reports nearly 74 percent of homeless veterans are likely to have medical problems upon admission to either VA or community-based assistance programs. About 70 percent will have alcohol-related problems; 63 percent will have drug abuse histories; and 69 percent will have a mental illness diagnosis. These conditions can interrupt their ability to keep a job, establish savings, and in some cases, live with their families. Veterans' family, social, and professional networks may have been damaged and their lives disrupted due to extensive mobility while in service or lengthy periods away from their hometowns and their civilian jobs. These problems are directly traceable to their experience in military service or to the difficulty of transitioning back into civilian society.

While most Americans believe our Nation's veterans are well-supported, in fact many go without the services they require and are eligible to receive. According to a Congressional staff analysis of 2000 U.S. Census data, 1½ million veterans have incomes that fall below the Federal poverty level, including 634,000 with incomes below 50 percent of poverty. Neither the VA nor State and county veteran service departments are adequately funded to respond to these veterans' health, housing, and supportive services needs. Moreover, community-based and faith-based service providers also lack sufficient resources to keep up with the number of veterans needing help.

The VA reports its homeless veteran programs serve about 100,000 veterans annually. NCHV member community-based organizations (CBOs) serve 150,000 each year. With an estimated 400,000 veterans experiencing homelessness at some time during the year, and the VA reaching only 25 percent and CBOs reaching 35 percent of those in need, that still leaves almost 40 percent of the nation's homeless veterans who do not receive the help they need. It is likely some of these veterans are receiving assistance from other community resources, but there is no way to determine the extent or nature of services being provided.

In testimony presented to Congress in 2006, a U.S. Department of Veterans Affairs (VA) representative reported the number of homeless veterans on the streets of America on any given night decreased by nearly 25 percent during the last 5 years, from about 250,000 to 190,000. Despite the reported decrease, many veterans still need help. Findings from a survey conducted by NCHV in November 2006 suggest the homeless veteran population in America may be experiencing significant changes. Homeless veterans receiving services today are aging and many are in need of permanent supportive housing. With the increase in the number of women serving in Iraq and Afghanistan, the percentage of women veterans seeking services is growing. According to studies published by the New England Journal of Medicine and the VA, a growing number of combat veterans of Operation Iraqi Freedom, Operation Enduring Freedom and the Global War on Terror are returning home and suffering from war-related conditions including PTSD and Traumatic Brain Injury, which may put them at risk for homelessness.

Homeless Provider Grant and Per Diem Program

Administered by the U.S. Department of Veterans Affairs, the Homeless Providers Grants and Per Diem (GPD) program is the nation's largest VA program to help address the needs of homeless veterans and supports development of transitional, community-based housing and delivery of supportive services. The program also funds GPD liaisons who coordinate outreach, case management, referrals to benefits counselors, and linkage to health care and housing assistance. Also funded under the GPD program are Special Needs Grants, which assist homeless women veterans including homeless women veterans with children, in addition to veterans who are chronically mentally ill, frail elderly and terminally ill.

The Homeless Provider Grant and Per Diem Program provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans. The GPD program is an essential component of the VA's continuum of care for homeless veterans, assuring the availability of social services, employment supports, and direct treatment or referral to medical treatment.

In September 2006 the Government Accountability Office (GAO) released its study, *Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program*. The agency found while VA has attempted to improve its services and increase the capacity of the GPD program, an additional 9,600 transitional housing beds are needed to meet the current demand. According to the study, VA reports a total of 45,000 transitional beds are needed and has identified 35,400 beds available from various sources, including the GPD program, resulting in a shortfall of about 9,600 beds. In FY 2005, the GPD program had about 8,000 available for homeless veterans. GAO states VA plans to increase GPD beds by 2,200 in the near future.

NCHV is pleased that both the House and Senate have already passed bills increasing FY08 appropriations for the GPD program to the fully authorized level of $130,000,000. Funding at this level will make more beds available to serve the expected number of men and women returning from Iraq and Afghanistan who are at risk of homelessness. NCHV is hopeful Congress will soon pass a final bill that includes this level of funding and the bill will be signed into law.

Payment for Services

In addition to needed increased program funding, however, NCHV believes the mechanism for paying providers under the Homeless Providers Grant and Per Diem Program (GPD) must be simplified. Current law (38 U.S.C. 2012(a)(2)) authorizes the VA Secretary to provide per diem payments to GPD providers at a rate not to exceed the rate authorized for State homes for domiciliary care. GPD providers report even this maximum rate (up to $31.30 per day) provides far less than the actual daily cost of care to a veteran in the GPD program.

Moreover, VA has applied current law in a manner such that GPD providers must expend a significant level of effort and resources to gather and submit extensive documentation about each source of income and the location of costs for each homeless veteran being served with GPD funds. Providers often experience lengthy ongoing communication with the VA and questions regarding expenses incurred and accountability, resulting in a delay in timely reimbursement and ultimately, interruption of services to their clients. The accounting burden is particularly onerous for smaller faith-based and community-based organizations, and is contrary to the aim of the President's Faith-Based and Community Initiative, which seeks to welcome grassroots organizations to Federal funding streams.

Often the VA demands repayment of funds when providers temporarily have empty beds—the problem that comes about because the formula is based on an unsuitable model. At the time the original law was written, Congress was limited in determining how services to veterans outside traditional VA facilities should be reimbursed. As a result, the rate authorized for State homes for domiciliary care was used as the standard for paying homeless veteran service providers. Over the past several years, however, evidence has shown because clients in the two settings have different needs a payment system reflecting those needs and the more comprehensive services they are receiving must be applied. Residents receiving domiciliary care in State homes are more likely to remain permanently in VA facilities while the goal of community based homeless veteran service providers is to promote independent living for its clients and reintegration back into civilian life. The current GPD system is too rigid and doesn't reflect the reality of hiring and compensating staff even when beds are temporarily empty.

To address these issues, NCHV urges Congress to introduce legislation that would provide relief to current community- and faith-based providers in addition to organizations that may be interested in applying to the GPD program in the future. The new legislation would revise the per diem payment program to allow payments to be related to service costs rather than a capped rate and would also encourage high cost service areas to participate. The revised system would allow the Secretary to increase annually and adjust accordingly the rate of payment to providers to reflect changes in the cost of furnishing services in a particular geographic area. The Secretary would set a maximum amount providers would receive based on available funds.

To ensure GPD funds are being spent in accordance with the purpose of the GPD program, NCHV supports statutory language requiring the VA Secretary to develop a reasonable system of outcome and performance measurement of GPD providers. In the current arena, the VA Homeless Grant and Per Diem liaison (HGPD) assigned to each grant program through the local VA medical center, provides continuous oversight throughout the year and conducts an annual inspection of each program. Results of these activities are reported to the VA HGPD Office. Oversight includes an inspection of the physical plant where the program operates, and a review and evaluation of the overall program including veterans' goals, objectives and out-

comes as described in the original grant proposal that received the award. Maintaining the reporting process between the VA HGPD Office and the Secretary ensures the Secretary has in place a procedure that can determine if GPD funds are justified and utilized appropriately. Grant recipients provide the VA with information on financial integrity, solvency, operational accounting systems, as well as an annual independent audit.

Use of Other Funding

In addition to revising the GPD payment system, new legislation should change the requirements for grant recipients and allow service providers to use other available sources of income besides the GPD program to furnish services to homeless veterans. These sources may include payments or grants from other departments and agencies of the United States or from departments or agencies of State or local Government.

While the current law was intended to ensure VA per diem payments do not replace payments or contributions from other income sources, it has instead created the unintended consequence of penalizing GPD providers successful in securing other sources of income for services to homeless veterans by reducing their per diem payment rate. Thus, the predictable effect of this provision is that it discourages providers from developing partnerships with other Federal agencies or State and local Governments. Congress should devise a payment provision that encourages GPD providers to continue to seek funding from non-VA sources in a manner that does not penalize them if they are successful.

Matching Funds

All payment modifications should also allow VA funds to be used as a match or leverage for other Federal funds and allow other Federal funds to be used without offset by VA. When GPD providers are able to receive the maximum rate in addition to other income sources, they are able to expand the scope and quantity of services to homeless veterans and increase the likelihood of their successful reintegration into the community. Conversely, when GPD providers are forced to use other sources of income to offset any reduction in payments made under the GPD program, as is currently the case, new services cannot be offered. Providers may not use such other income to develop and support additional housing units, provide veterans a more robust service package, or serve homeless veterans not qualified for GPD support.

Currently, GPD grantees are being required to submit extensive documentation on all of their sources of project funding in order to secure per diem payments at the maximum rate permitted by statute, straining grantees and VA alike. If the GPD program is to remain viable in the future, Congress needs to simplify the conditions under which GPD payment amounts are established.

Conclusion

The verdict is clear from homeless veteran service providers and veterans' advocates that the current GPD payment mechanism affects the ability of community- and faith-based organizations to effectively and efficiently serve veterans experiencing homelessness. We urge Congress to address this situation in whatever legislation is deemed an appropriate vehicle.

Thank you for providing NCHV an opportunity to present our views. I am happy to answer your questions.

Prepared Statement of Kathryn E. Spearman,
President and Chief Executive Officer,
Volunteers of America of Florida

Chairman Michaud, Ranking Member Miller and Members of the Subcommittee:

Thank you for the invitation to testify today and for all you do to assist our Nation's veterans. Volunteers of America of Florida is a statewide 501(c)(3) non-profit, faith-based social service community provider in Florida for 87 years. We are an affiliate of Volunteers of America, a national organization whose headquarters are located in the Washington, DC area, in existence for 111 years, with affiliates in 44 states.

Volunteers of America of Florida, in partnership with various committed funding sources, provides housing and services to the homeless, low-income elderly, persons with mental illness, and persons with developmental disabilities. With a continuum of services, Volunteers of America offers housing, health care, training, education and employment services to advance self-sufficiency. Housing and support services

are offered in 13 Florida cities: Jacksonville, Gainesville, Tampa, Sebring, Bradenton, Clearwater, Orlando, Cocoa, Lakeland, Miami, Ft. Lauderdale, Pompano, and Key West. Currently, there are new projects in development in Pensacola, Punta Gorda, and Lake City, and assistance is being offered to potential providers in Trenton and Sebastian, Florida.

Florida attracts many homeless veterans, and Volunteers of America of Florida has been focused on addressing the needs of these individuals for the past 10 years. We partner with the VA Grant and Per Diem Program in serving this population of veterans. This partnership is demonstrated by the fact that Volunteers of America of Florida and VISN 8 have jointly responded to five major hurricanes utilizing the Mobile Service Center which we will mention later in our talk. On any given night in Florida between 17,000 and 23,000 homeless veterans are living in shelters, on the streets, in encampments, on derelict boats or in other places not meant for human habitation. Volunteers of America of Florida currently has transitional housing and support services capacity for 216 homeless veterans in seven Florida cities: Jacksonville, Gainesville, Cocoa, Key West, Miami, Ft. Lauderdale, and Lake City. There are 171 beds through the VA Grant and Per Diem Program and 45 through our HUD Supportive Housing Programs. Another 81 beds are in development bringing our service capacity to 297 veterans in nine Florida cities and surrounding communities. Our first and most innovative Grant and Per Diem program is the Florida Veterans Mobile Service Center, a 40-foot state-of-the-art vehicle with a fully contained medical, dental and health service facility that outreaches to homeless veterans throughout the state. Veterans also benefit from a Multi-Service Center in some cities.

Volunteers of America of Florida currently has the largest number of Veterans Affairs Grant and Per Diem supportive housing and service programs in Florida, as well as one of the largest number of HUD McKinney-Vento Supported Housing Programs in the State.

Our service to veterans is based on excellent partnerships and common goals to support the needs of homeless veterans. As a provider, I appreciate the dedication of Roger Casey and his staff to make the program what it needs to be; the continual funding to add more beds; the grant segment which provides tremendous leverage and incentive; the opportunity for the VA and the community to partner to address the needs of homeless veterans; the per diem that strengthens the operations and program; the service center potential; and the strategic gateway for veterans to live in and be part of the community.

Volunteers of America of Florida's success with homeless veterans is founded in strong partnerships, the ability to work statewide, a continuum of housing options and array of support services, and diligence in combining Federal and local resources to get the job done. Our 10 years of experience in working with homeless veterans, first in outreach and then in providing housing and support services including multi service centers, has led us to an increasing awareness of the issues facing Grant and Per Diem providers. From a provider perspective I will spend the rest of my testimony offering information and suggestions.

Partnership—The overall partnership between the VA and the community needs strengthening. Local providers address the needs of veterans everyday and complement the VA services. We accept this as our role and we would like the VA to value that role in partnership—often a tall order I believe for the "big VA". In service to the homeless veterans, local community providers offer easier accessibility, 24/7 availability of staff in our programs, fewer barriers to receive immediate service, and a more coordinated individualized, and timely approach to the needs of each homeless veteran. Providers are good housing developers; problem solvers; resource developers; and grant writers. We are a linkage for the veteran to the community where we offer an expansion to VA's clinical and substance abuse treatment as well as training and education in preparation for employment.

Furthermore, the community needs the VA and its tremendous assets and resources in order to meet the goal of ending homelessness among veterans. The homeless veteran needs us both and the homeless veteran needs us to work together. A partnership approach does work and Volunteers of America of Florida is becoming more selective in its funding partners because so much more can be accomplished if we sit at the same table trying to find ways to reach an agreed upon outcome. With a good partnership comes shared risk because we own the problem together.

- *Suggestion:* A work group to advise on a provider friendly/VA accountability and funding mechanism for Grant and Per Diem payment with representation from all members of the partnership.

VA Medical Center Relationship—Volunteers of America of Florida has worked well with the Health Care for Homeless Veterans and Compensated Work Therapy staff. In my experience, the staff from the VA hospitals that provide contract management and site inspections often lack the same goals as the VA Grant and Per Diem Program. However, as in many monitoring situations, it becomes confusing when the monitoring staff misconstrues their role as the expert in housing development, safety, service delivery, client intake, and generally—everything that is good for the veterans. I believe being a more integral part of the Grant and Per Diem staff and its strategies to work with the community could be beneficial.

- *Suggestion:* Staff those positions under Grant and Per Diem. Training, scheduling and a positive attitude could build a better rapport with community providers serving veterans. We could actually problem solve as a team. At a minimum the hospital representatives, as well as everyone representing the VA Grant and Per Diem Program, need to focus on the positive partnership.

Helping the Homeless Veterans—In order to move a homeless veteran to a healthful and productive life in the Grant and Per Diem Program, most of the following services will be required:

- Outreach to identify, locate, establish trust and rapport, and link veterans to services
- Immediate access to shelter, food, clothing, and health care
- Assessment of need
- Housing placement
- Medical and dental care
- Support Services—transportation, linkage to assistance and benefits, legal aid, and building a personal support system
- Mental Health and/or Substance Abuse Treatment
- Training and education, and employment assistance
- Employment assistance
- Community integration, support networks
- Relocation to permanent housing

Outreach and services will be successful when they are conducted to build trust and respect. Recognition should be given to the importance of all sources that help the homeless veteran succeed. I must say that I doubt most people realize how disengaged and disabled many of the homeless veterans are when they enter our programs. Drug and alcohol addiction is very serious and disruptive to rebuilding a life acceptable to our society.

Costs in Relation to the VA Grant and Per Diem Payment—The complex barriers experienced by our Nation's homeless veterans reinforce the need to be flexible as a service provider. Costs for housing and services must be constantly evaluated to offer the highest quality of service. The following are some industry costs for your information on this topic. While costs will vary by factors such as quality and volume, the information below shows activities and associated costs.

Activity	Cost
Housing Management	$25/day
Clinical Care (non clinic)	$32/day
Service Center Operation (for serving 50 veterans)	$1,000/day

Therefore, the $32/day per diem note will always fall short of paying in total for what is needed. Identification and combining of resources is essential and should be encouraged strongly. In my opinion, the VA Grant and Per Diem service center payment does not relate to operating a center.

Construction, rehab and acquisition require a 35 percent cash match from the provider. This usually comes from additional funding sources that are easier to access with the VA portion committed as a grant and a per diem to strengthen the ability to operate. Flexibility needs to be exercised to create projects that offer beds to homeless veterans. There are many creative ways to combine development funding or put together assets of providers, VA grant, and financing. It is crucial also that VA Grant and Per Diem be understood as providers attempt to mesh funding and funders' requirements. It is not a perfect process and each is different and often challenging.

- Suggested Options of Service Payment:

1. Provider prepares an expense budget reflecting housing and services expenses they want the VA to pay for. The provider is then monitored according to that proposed budget and the services those expenses covered. VA is flexible and helpful as circumstances require adjustments. Cost is impacted by the level and type of service.
2. Determine a housing base per diem and then two or three levels of service per diem as an overlay (basic to more intensive).
3. Determine outcomes desired and steps to arrive at those outcomes. Then determine cost and pay the provider monthly (1/12) of budget if 80 percent of outcomes are being met or if veterans are moving toward independence that month (documented). Volunteers of America of Florida has two pilots of this nature with the State Department of Children and Families, Office of Substance Abuse and Mental Health. It has a remarkable impact on how services are delivered!

   Note: The VA must pay their portion of administrative overhead based on a reasonable percent. It costs a viable organization between 12 and 25 percent (12–25 percent) of administrative costs—the higher percent for the smaller organization.

The flexibility we build now, in this program, should also be with an eye to the future when we will be focused on a new era of veterans with a whole new set of circumstances and needs. Our work over the last decade has been primarily with homeless veterans who served during the Vietnam era. Veterans now returning from Operation Iraqi Freedom or Operation Enduring Freedom should benefit from the lessons we have learned in developing support and interventions. Our returning troops have Post Traumatic Stress Disorder, Traumatic Brain Injury, and other serious mental health/substance abuse disorders which will require services on a longer term basis. Please consider the need for permanent supported housing for these veterans. As we work together to address program improvements, we will be better prepared to continue to meet the needs of current homeless veterans and wisely anticipate the needs of our returning troops.

In closing, I hope the pressure on the Grant and Per Diem Program will lift so the staff can more effectively advance the Program goals. We all need to be more secure in what we are doing and why we are doing it! When we embrace common goals to serve and support homeless veterans, and reach out with a sincere helping hand, powerfully positive outcomes will result.

Thank you for the opportunity to share my views on this important and worthwhile program. I hope my comments are representative of other providers or that their opinions are represented in the comments of my other colleagues testifying with me today.

Prepared Statement of Daniel Bertoni, Director, Education, Workforce, and Income Security Issues, U.S. Government Accountability Office

Homeless Veterans Programs—Bed Capacity, Service and Communication Gaps Challenge the Grant and Per Diem Program

GAO Highlights

Why GAO Did This Study

The Subcommittee on Health of the Committee on Veterans' Affairs asked GAO to discuss its recent work on the Department of Veterans Affairs' (VA) Homeless Providers Grant and Per Diem (GPD) program.

GAO reported on this subject in September 2006, focusing on (1) VA's estimates of the number of homeless veterans and transitional housing beds, (2) the extent of collaboration involved in the provision of GPD and related services, and (3) VA's assessment of program performance.

What GAO Found

VA estimates that about 196,000 veterans nationwide were homeless on a given night in 2006, based on its annual survey, and that the number of transitional beds available through VA and other organizations was not sufficient to meet the needs of eligible veterans. The GPD program has quadrupled its capacity to provide transitional housing for homeless veterans since 2000, and additional growth is planned. As the GPD program continues to grow, VA and its providers are also grappling

with how to accommodate the needs of the changing homeless veteran population that will include increasing numbers of women and veterans with dependents.

The GPD providers we visited collaborated with VA, local service organizations, and other State and Federal programs to offer a broad array of services designed to help veterans achieve the three goals of the GPD program—residential stability, increased skills or income, and greater self-determination. However, most GPD providers noted key service and communication gaps that included difficulties obtaining affordable permanent housing and knowing with certainty which veterans were eligible for the program, how long they could stay, and when exceptions were possible.

VA data showed that many veterans leaving the GPD program were better off in several ways—over half had successfully arranged independent housing, nearly one-third had jobs, one-quarter were receiving benefits, and significant percentages showed progress with substance abuse, mental health or medical problems or demonstrated greater self-determination in other ways. Some information on how veterans fare after they leave the program was available from a onetime follow-up study of 520 program participants, but such data are not routinely collected.

We recommended that VA take steps to ensure that GPD policies and procedures are consistently understood and to explore feasible means of obtaining information about the circumstances of veterans after they leave the GPD program. VA concurred and, following our review, has taken several steps to improve communications and to develop a process to track veterans' progress shortly after they leave the program. However following up at a later point might yield a better indication of success.

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to discuss the Homeless Providers Grant and Per Diem (GPD) program, the largest program of its kind administered by the Department of Veterans Affairs (VA). On any given night in the United States, an estimated 750,000 people, including veterans, are homeless and may sleep on the streets or in shelters. Veterans constitute about one-third of the adult homeless population, and many veterans who are not yet homeless may be at risk. To address the needs of these homeless veterans, VA officials told us that through the GPD program they fund over 300 grants to local agencies to house approximately 15,000 homeless veterans over the course of a year at a cost of about $95 million. The program is not designed to serve all homeless veterans—it focuses on transitional housing and supportive services for veterans who are most in need, including those who have had problems with mental illness, substance abuse, or both.

My statement draws on GAO's report on this program issued in September 2006 that reviewed (1) VA's estimates of the number of homeless veterans and transitional housing beds, (2) the extent of collaboration involved in the provision of GPD and related services, and (3) VA's assessment of program performance.[1] I have also included information we obtained in following up on VA's efforts to implement our recommendations.

In summary, VA reported in 2006 that about 196,000 veterans were homeless and that not enough transitional beds were available through VA and other organizations to meet the needs of homeless veterans eligible to use this assistance. To help meet these needs, the GPD program has quadrupled its capacity since 2000 to about 8,200 beds, and additional growth is planned. In addition to increasing transitional bed capacity, VA and its providers are also grappling with how to accommodate the needs of the changing homeless veteran population that will include increasing numbers of women and veterans with dependents. When we met with GPD providers who operate the program and their local VA liaisons, we found that they were working collaboratively with other organizations to deliver supportive services, but most also noted key resource and communications gaps. Specifically, providers reported difficulties finding affordable permanent housing for veterans ready to leave the program. In addition the eligibility rules for the GPD program were not always clear, a fact that could cause confusion and could keep veterans from obtaining needed care. VA data showed that many veterans were better off in terms of housing; employment; receipt of public benefits; and progress with substance abuse, mental health, or medical problems at the time they left the program, but VA did not know how they were faring months or years later.

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[1] GAO, Homeless Veterans Programs: Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program, GAO–06–859 (Washington, D.C. Sept. 11, 2006).

We recommended that VA take steps to ensure that GPD policies and procedures are consistently understood and to explore feasible means of obtaining information about the circumstances of veterans after they leave the GPD program. VA concurred and, following our review, has taken several steps to improve communications and to develop a process to track veterans' progress shortly after they leave the program. However following up at a later point might yield a better indication of success.

Background

The GPD program is one of six housing programs for homeless veterans administered by the Veterans Health Administration, which also undertakes outreach efforts and provides medical treatment for homeless veterans.[2] VA officials told us in Fiscal Year 2007 they spent about $95 million on the GPD program to support two basic types of grants—capital grants to pay for the buildings that house homeless veterans and per diem grants for the day-to-day operational expenses.[3] Capital grants cover up to 65 percent of housing acquisition, construction, or renovation costs. The per diem grants pay a fixed dollar amount for each day an authorized bed is occupied by an eligible veteran up to the maximum number of beds allowed by the grant—in 2007 the amount cannot exceed $31.30 per person per day. VA pays providers after they have housed the veteran, on a cost reimbursement basis. Reimbursement may be lower for providers whose costs are lower or are offset by funds for the same purpose from other sources.

Through a network of over 300 local providers, consisting of nonprofit or public agencies, the GPD program offers beds to homeless veterans in settings free of drugs and alcohol that are supervised 24 hours a day, 7 days a week. Most GPD providers have 50 or fewer beds available, with the majority of providers having 25 or fewer. Program rules generally allow veterans to stay with a single GPD provider for 2 years, but extensions may be granted when permanent housing has not been located or the veteran requires additional time to prepare for independent living. Providers, however, have the flexibility to set shorter timeframes. In addition, veterans are generally limited to a total of three stays in the program over their lifetime, but local VA liaisons may waive this limitation under certain circumstances. The program's goals are to help homeless veterans achieve residential stability, increase their income or skill levels, and attain greater self-determination.

To meet VA's minimum eligibility requirements for the program, individuals must be veterans and must be homeless. A veteran is an individual discharged or released from active military service. The GPD program excludes individuals with a dishonorable discharge, but it may accept veterans with shorter military service than required of veterans who seek VA health care. A homeless individual is a person who lacks a fixed, regular, adequate nighttime residence and instead stays at night in a shelter, institution, or public or private place not designed for regular sleeping accommodations.[4] GPD providers determine if potential participants are homeless, but local VA liaisons determine if potential participants meet the program's definition of veteran. VA liaisons are also responsible for determining whether veterans have exceeded their lifetime limit of three stays in the GPD program and for issuing a waiver to that rule when appropriate. Prospective GPD providers may identify additional eligibility requirements in their grant documents.

While program policies are developed at the national level by VA program staff, the local VA liaisons designated by VA medical centers have primary responsibility for communicating with GPD providers in their area. VA reported that in Fiscal Year 2007, there were funds to support 122 full-time liaisons.[5]

VA Has Expanded GPD Program Capacity to Help Meet Homeless Veterans' Needs, but Demand Still Exceeds Supply

Since Fiscal Year 2000, VA has quadrupled the number of available beds and significantly increased the number of admissions of homeless veterans to the GPD pro-

[2] The other five programs are the Contracted Residential Treatment Program, the Domiciliary Residential Rehabilitation and Treatment Program, the Compensated Work Therapy/Transitional Residence Program, the Loan Guarantee for Multifamily Transitional Housing, and the Housing and Urban Development-VA Supported Housing program.

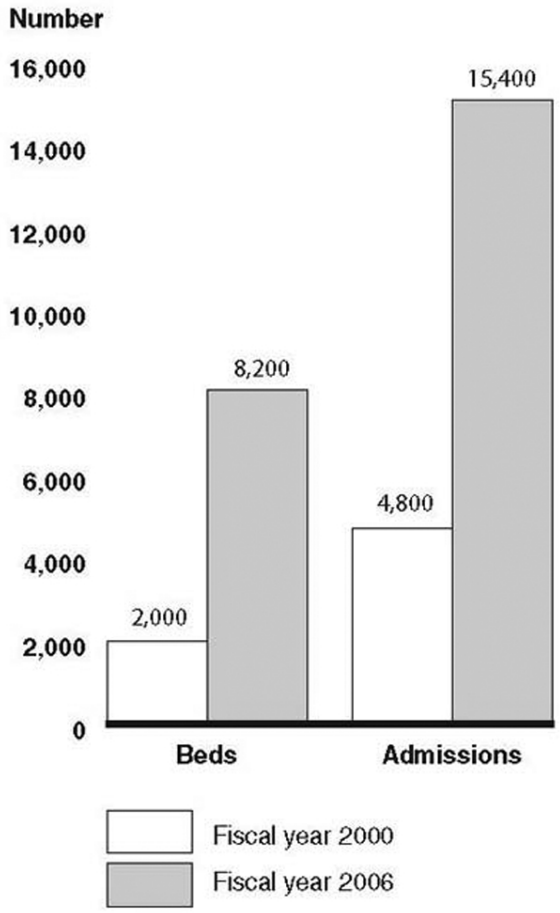
[3] On a limited basis, special needs grants are available to cover the additional costs of serving women, frail elderly, terminally ill, or chronically mentally ill veterans.

[4] The definitions appear at 42 U.S.C. § 11302 and 38 C.F.R. § 61.1.

[5] Liaisons told us in 2006 that they experienced large caseloads and multiple GPD responsibilities—including eligibility determination, verification of intake and discharge information, case management, fiscal oversight, monitoring program compliance and inspections of GPD facilities, among other duties. To address some of these concerns, VA obtained funding to increase the number of full-time positions to 122.

gram in order to address some of the needs identified through its annual survey of homeless veterans. In Fiscal Year 2006, VA estimated that on a given night, about 196,000 veterans were homeless and an additional 11,100 transitional beds were needed to meet homeless veterans' needs. However, this need was to be met through the combined efforts of the GPD program and other Federal, state, or community programs that serve the homeless. VA had the capacity to house about 8,200 veterans on any given night in the GPD program. Over the course of the year, because some veterans completed the program in a matter of months and others left before completion, VA was able to admit about 15,400 veterans into the program, as shown in figure 1. Despite VA rules allowing stays of up to 2 years, veterans remained in the GPD program an average of 3 to 5 months in Fiscal Year 2006.

Figure 1—Numbers of GPD Admissions and Beds in Fiscal Years 2000 and 2006



The need for transitional housing beds continues to exceed capacity, according to VA's annual survey of local areas served by VA medical centers. The number of transitional beds available nationwide from all sources increased to 40,600 in Fiscal Year 2006, but the need for beds increased as well. As a result, VA estimates that about 11,100 more beds are needed to serve the homeless, as shown in table 1. VA officials told us that they expect to increase the bed capacity of the GPD program to provide some of the needed beds.

Table 1—Available and Needed Transitional Beds for Homeless Veterans, Fiscal Year 2006

Available and Needed Transitional Beds	FY 2006
Transitional beds needed	51,700
Total transitional beds available, including GPD	40,600
Additional beds still needed	11,100

Source: GAO analysis of VA's annual survey estimates rounded to nearest 100.

Most homeless veterans in the program had struggled with alcohol, drug, medical or mental health problems before they entered the program. Over 40 percent of homeless veterans seen by VA had served during the Vietnam era, and most of the remaining homeless veterans served after that war, including at least 4,000 who served in military or peacekeeping operations in the Persian Gulf, Afghanistan, Iraq, and other areas since 1990. About 50 percent of homeless veterans were between 45 and 54 years old, with 30 percent older and 20 percent younger. African-Americans were disproportionately represented at 46 percent, the same percentage as non-Hispanic whites. Almost all homeless veterans were men, and about 76 percent of veterans were either divorced or never married.

An increasing number of homeless women veterans and veterans with dependents are in need of transitional housing according to VA officials and GPD providers we visited. The GPD providers told us in 2006 that women veterans had sought transitional housing; some recent admissions had dependents; and a few of their beds were occupied by the children of veterans, for whom VA could not provide reimbursement. VA officials said that they may have to reconsider the type of housing and services that they are providing with GPD funds in the future, but currently they provide additional funding in the form of special needs grants to a few GPD programs to serve homeless women veterans.

GPD Providers Collaborate to Offer a Range of Services, but Face Challenges in Helping Veterans

VA's grant process encourages collaboration between GPD providers and other service organizations. Addressing homelessness—particularly when it is compounded by substance abuse and mental illness—is a challenge involving a broad array of services that must be coordinated. To encourage collaboration, VA's grants process awards points to prospective GPD providers who demonstrate in their grant documents that they have relationships with groups such as local homeless networks, community mental health or substance abuse agencies, VA medical centers, and ancillary programs. The grant documents must also specify how providers will deliver services to meet the program's three goals—residential stability, increased skill level or income, and greater self-determination.

The GPD providers we visited often collaborated with VA, local service organizations, and other State and Federal programs to offer the broad array of services needed to help veterans achieve the three goals of the GPD program. Several providers worked with the local homeless networks to identify permanent housing resources, and others sought Federal housing funds to build single-room occupancy units for temporary use until more permanent long-term housing could be developed.[6] All providers we visited tried to help veterans obtain financial benefits or employment. Some had staff who assessed a veteran's potential eligibility for public benefits such as food stamps, Supplemental Security Income, or Social Security Disability Insurance. Other providers relied on relationships with local or State officials to provide this assessment, such as county veterans' service officers who reviewed veterans' eligibility for State and Federal benefits or employment representatives who assisted with job searches, training, and other employment issues. GPD providers also worked collaboratively to provide health care-related services—such as mental health and substance abuse treatment, and family and nutritional counseling. While several programs used their own staff or their partners' staff to pro-

[6] Through the local Continuum of Care networks, the Department of Housing and Urban Development contracts with public housing agencies for the rehabilitation of residential properties that provide multiple single-room dwelling units. These agencies make Section 8 rental assistance payments generally covering the difference between a portion of the tenant's income (normally 30 percent) and the unit's rent to participating owners (i.e., landlords) on behalf of homeless individuals who rent the rehabilitated dwellings.

vide mental health or substance abuse services and counseling directly, some GPD providers referred veterans offsite—typically, to a VA local medical center.

Despite GPD providers' efforts to collaborate and leverage resources, GPD providers and VA staff noted gaps in key services and resources, particularly affordable permanent housing for veterans ready to leave the GPD program. Providers also identified lack of transportation, legal assistance, affordable dental care,[7] and immediate access to substance abuse treatment facilities as obstacles for transitioning veterans out of homelessness. VA staff in some of the GPD locations we visited told us that transportation issues made it difficult for veterans to get to medical appointments or employment-related activities. While one GPD provider we visited was able to overcome transportation challenges by partnering with the local transit company to obtain subsidies for homeless veterans, transportation remained an issue for GPD providers that could not easily access VA medical centers by public transit. Providers said difficulty in obtaining legal assistance to resolve issues related to criminal records or credit problems presented challenges in helping veterans obtain jobs or permanent housing. In addition, some providers expressed concerns about obtaining affordable dental care and about wait lists for veterans referred to VA for substance abuse treatment.

We found that some providers and staff did not fully understand certain GPD program policies—which in some cases may have affected veterans' ability to get care. For instance, providers did not always have an accurate understanding of the eligibility requirements and program stay rules, despite VA's efforts to communicate its program rules to GPD providers and VA liaisons who implement the program. Some providers were told incorrectly that veterans could not participate in the GPD program unless they were eligible for VA health care. Several providers understood the lifetime limit of three GPD stays but may not have known or believed that VA had the authority to waive this rule.[8] As a consequence, we recommended that VA take steps to ensure that its policies are understood by the staff and providers with responsibility for implementing them.

In response to our recommendation that VA take steps to ensure that its policies are understood by the staff and providers with responsibility for implementing them, VA took several steps in 2007 to improve communications with VA liaisons and GPD providers, such as calling new providers to explain policies and summarizing their regular quarterly conference calls on a new Web site, along with new or updated manuals. Language on the number and length of allowable stays in the providers' guide has not changed, however.

VA Data Show Many Veterans Have Housing and Jobs on Leaving the Program and Plans Are Under Way for Follow-up

VA assesses performance in two ways—the outcomes for veterans at the time they leave the program and the performance of individual GPD providers. VA's data show that since 2000, a generally steady or increasing percentage of veterans met each of the program's three goals at the time they left the GPD program.

Since 2000, proportionately more veterans are leaving the program with housing or with a better handle on their substance abuse or health issues. During 2006, over half of veterans obtained independent housing when they left the GPD program, and another quarter were in transitional housing programs, halfway houses, hospitals, nursing homes, or similar forms of secured housing.[9] Nearly one-third of veterans had jobs, mostly on a full-time basis, when they left the GPD program. One-quarter were receiving VA benefits when they left the GPD program, and one-fifth were receiving other public benefits such as Supplemental Security Income. Significant percentages also demonstrated progress in handling alcohol, drug, mental health, or medical problems and overcoming deficits in social or vocational skills. For example, 67 percent of veterans admitted with substance problems showed progress in handling these problems by the time they left. Table 2 indicates the numbers or percentages involved.

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[7] VA issued a directive for a onetime dental care opportunity for homeless veterans (VHA Directive 2002–080) in line with 38 U.S.C. § 101 note. VA officials told us that funding was provided in 2006 to implement this directive.

[8] VA may waive the lifetime limit on program stays if the services offered are different from those previously provided and may lead to a successful outcome. The VA liaisons must review and approve or deny the waiver based on their best clinical assessment of the individual case.

[9] Independent housing comprises apartments, rooms, or houses. While independent housing may be a more desirable outcome, for some veterans, including those with severe disabilities, secured housing may be more appropriate.

Table 2—Number Served by VA's Health Care for Homeless Veterans and Grant and Per Diem Program and Veterans' Outcomes, Fiscal Years 2000 and 2006

Participants Served and Outcomes	2000	2006
Number of		
• veterans treated by VA's Health Care for Homeless Veterans' (HCHV) staff	43,082	60,857
• intake assessments of homeless veterans by HCHV staff [a]	34,206	38,667
• admissions of veterans to GPDs	4,841	15,433
• discharges from GPDs	4,020	15,037 [b]
Days a veteran stays at a GPD, on average	91	139 [c]
Housing stability outcomes: Number of discharges from GPDs with		
• independent housing	1,163	7,723
• placement in halfway house or institution such as hospital, nursing home, or domiciliary	991	3,648
Increased income or skills outcomes: Number of discharges from GPDs with		
• full-time or part-time employment	1,404	4,766
• VA benefits [d]	Not Available	3,648
• Other public benefits [d]	Not Available	3,001
Greater self-determination outcomes: Percentage of discharges from GPDs with		
• improved alcohol, drug, mental health [e]	38–42	60–67
• improved medical, social/vocational condition [e]	43–46	57–62
• success in meeting GPD provider requirements	30	47

Source: GAO analysis of VA data aggregated from individual discharge forms completed by VA or GPD providers for veterans at the time they leave the program and compiled in annual reports by VA's evaluation center.

[a] Intake assessments are completed by HCHV staff when they first encounter a homeless veteran, unless the contact is casual and no services are offered or referrals made. After a year, new assessments are required if VA care or services are provided and VA staff have not been working with the veteran.

[b] Number of discharges with complete data on their status is 14,710 and is used to calculate all numbers below.

[c] Mean is shown. Median is 81 days.

[d] Numbers shown here include veterans who receive both types of benefits as well as those who receive only the designated benefits.

[e] Percentages are ranges showing the highest and lowest of each of two or three outcome measures.

VA's Office of Inspector General (OIG) found when it visited GPD providers in 2005–2006 that VA officials had not been consistently monitoring the GPD providers' annual performance as required. [10] The GPD program office has since moved to enforce the requirement that VA liaisons review GPD providers' performance when the VA team comes on-site each year to inspect the GPD facility.

To assess the veterans' success, VA has relied chiefly on measures of veterans' status at the time they leave the GPD program rather than obtaining routine information on their status months or years later. In part, this has been due to concerns about the costs, benefits, and feasibility of more extensive follow-up. However, VA completed a onetime study in January 2007 that a VA official told us cost about $1.5 million. The study looked at the experience of a sample of 520 veterans who participated in the GPD program in five geographic locations, including 360 who responded to interviews a year after they had left the program. Generally, the find-

[10] Veterans Affairs Office of Inspector General, Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program, Report No. 04–00888–215 (Washington, D.C.: Sept. 20, 2006).

ings confirm that veterans' status at the time they leave the program can be maintained.

We recommended that VA explore feasible and cost-effective ways to obtain information on how veterans are faring after they leave the program. We suggested that where possible they could use data from GPD providers and other VA sources, such as VA's own follow-up health assessments and GPD providers' follow-up information on the circumstances of veterans 3 to 12 months later. VA concurred and told us in 2007 that VA's Northeast Program Evaluation Center is piloting a new form to be completed electronically by VA liaisons for every veteran leaving the GPD program. The form asks for the veterans' employment and housing status, as well as involvement, if any, in substance abuse treatment, 1 month after they have left the program. While following up at 1 month is a step in the right direction, additional information at a later point would yield a better indication of longer term success.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or other Members of the Subcommittee may have.

Contact and Acknowledgements

For further information, please contact Daniel Bertoni at (202) 512–7215. Also contributing to this statement were Shelia Drake, Pat Elston, Lise Levie, Nyree M. Ryder, and Charles Willson.

Prepared Statement of George Basher, Chair,
Advisory Committee on Homeless Veterans,
U.S. Department of Veterans Affairs,
and Director, New York State Division of Veterans' Affairs

Chairman Michaud and Members of the Subcommittee:

I am pleased to be here today to discuss the VA Grant and Per Diem program serving homeless veterans. I thank you for the invitation to testify before the Subcommittee and discuss this worthy program. I have had the honor of serving as the Director of the New York State Division of Veterans' Affairs for the past 10 years and also currently serve as the Chair of the Department of Veterans Affairs Advisory Committee on Homeless Veterans. In both of these roles I have had an opportunity to witness not only the benefits of this program to those veterans who need a hand getting back on their feet but also the challenges it brings to the provider community. Recent estimates by the National Alliance to End Homelessness (NAEH) place the number of homeless individuals in the United States at 750,000. VA estimates the number of homeless veterans to be approximately 180,000, making homeless veterans one quarter of the entire homeless population.

Established by Congress in 1992, the Grant and Per Diem (GPD) program has provided nearly 10,000 transitional beds for homeless veterans through the efforts of over 300 community-based providers. These community- and faith-based organizations provide shelter, food, and supportive services to homeless veterans for up to 2 years for a per diem currently set at a maximum of $31.30 per day.

Originally designed to meet the needs of Vietnam era veterans, I believe it is time to revisit the Grant and Per Diem program in light of the need to also serve the veterans of the current conflict as well as those older veterans. VA estimates they have already seen over 1500 OEF/OIF veterans in various settings with several hundred referred to GPD providers for assistance.

The VA Advisory Committee on Homeless Veterans in its recent report discussed concerns about GPD. Specifically:

1. The VA GPD program uses a process to reimburse providers designed like the system VA uses to reimburse State Governments for the State Home program. The Advisory Committee is concerned this capped process discourages providers in high-cost areas from even applying. The current $31.30 rate is based in law on the rate paid to State Home programs. There is no basis in fact for the $31.30 rate in the State Home program and no defined rationale for determining that figure. Additionally, the current process does not allow the use of other Federal funds without offset by VA. While the State Home program rules were recently changed to allow this, the restriction still applies to GPD programs.
2. The accounting process required for reimbursement is a burden on small community-based providers. Asking this group to meet the same level of expertise as State Governments with large accounting staff is unreasonable and discourages participation. Additionally, recent audits of some providers have led to al-

legations of significant overpayments—sometimes years after the fact—based on differing interpretations of allowable expenses.

3. Community based GPD providers frequently use other Federal programs to augment the services provided to veterans. Current GPD regulations do not allow these funds to be used as a match for VA programs, often discouraging participation. Conversely, other Federal programs do allow VA funds to be used as a match, creating a disincentive to participate in VA programs.

The Advisory Committee recommended the Per Diem be revised to allow payments to be related to service costs rather than a capped rate, allowing higher cost areas where homeless veterans are often numerous to participate.

The Advisory Committee also recommended allowing other Federal funds to be used as a match to VA funds and also allow other Federal funds to be used without offset.

Incorporated in these recommendations is the implied recommendation that the current burdensome accounting process would be scrapped and replaced by a simpler mechanism to provide reimbursement and protect the taxpayer's interest. Paying a fee-for-services provided meets the needs of both the veteran client and the providers without placing an undue burden on either the providers or the Government.

Beyond adjustments to the existing Grant and Per Diem program, other related concerns need to be addressed. Historically, most homeless and housing services have been provided by the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS). VA housing initiatives have focused almost exclusively on transitional housing, reasoning that traditional VA programs coupled with GPD support services were all that was needed to return homeless veterans to a permanent housing environment. With 20 years experience in homeless veteran programs, we now know this is a simplistic view. Veterans with the co-morbidity of substance abuse and behavioral health disorders are frequently incapable of making the jump from transitional housing and programs to self-sufficiency. Experience has again taught that supportive permanent housing is often the most effective and economical way to have these individuals reenter the mainstream. The existing HUD–VASH program providing Section 8 vouchers is woefully inadequate due to a lack of specific appropriations for the program by HUD. The Advisory Committee has recommended to VA that HUD–VASH be expanded and further that VA look for opportunities to partner with HUD and other agencies to find innovative ways to bring permanent housing and supportive services to veterans. Consideration should be given to site-based Section 8 vouchers as a way to provide those services on an ongoing basis by community based providers. Success of programs such as New York City's New York, NY III initiative have demonstrated an integrated approach can provide positive results at an affordable cost.

The still ongoing Capital Asset Realignment for Enhanced Services (CARES) process VA is using to identify capital requirements for the next 20 years has identified a significant amount of surplus VA land and facilities. One of the Advisory Committee recommendations was to have VA make reuse of this land for veteran housing a priority. VA officials contend that the existing Enhanced Use Lease (EUL) program is adequate to meet that need, but experience shows the EUL to be a time consuming, cumbersome process fraught with opportunity for delay and lost opportunities. The Department of Defense Base Realignment and Closure (BRAC) process is much more efficient in terms of making reuse opportunities reality in a reasonable period of time.

There is a growing concern regarding women veterans. With women now making up nearly 20 percent of today's military, VA programs are being accessed by an increasing number of women veterans, including programs for homeless veterans.

There are unique challenges in this shift. Most VA programs were designed when the military was nearly exclusively male, necessitating changes by the Veterans Health Care Administration to facilities and procedures that are ongoing even today. Transitional housing programs for women veterans are rare, given the relatively low numbers involved and the economies of scale needed to provide services. Issues of safety and appropriateness of facilities likewise challenge traditional homeless service providers.

Another consideration is the authority of VA to only care for the veteran. Children who have no other parent to care for them also often accompany the increasing number of women veterans. Accessing VA services by these veterans means leaving children with other relatives or non-family caregivers; a difficult choice that often leads to walking away from VA care and looking for help elsewhere. VA should explore ways to cope with the changing demographics of the military and adjust ac-

cordingly, either in partnership with other agencies or through programmatic changes of its own.

The VA Grant and Per Diem program has provided a valuable service to homeless veterans over the past 15 years. Adjusting the program in light of experience is appropriate; creating new policy to meet the needs of returning veterans from the current conflict is a necessity.

Mr. Chairman, this concludes my formal remarks. I appreciate the opportunity to present my views and am prepared to answer any questions you or Members of the Subcommittee may have. Thank you.

Prepared Statement of Pete Dougherty, Director, Homeless Veterans Programs, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Michaud, and Members of the Subcommittee:

I am pleased to be here today to discuss the Department of Veterans Affairs' (VA) Grant and Per Diem program. This program is VA's largest and most comprehensive collaboration with more than 300 communities, faith based non-profit organizations, state, local and tribal Governments. I am pleased to be accompanied by Mr. Paul Smits, Director of Homeless and Residential Rehabilitation Programs within the Veterans Health Administration.

I would like to thank you for inviting us to join in today's hearing. I am always reminded that the efforts to engage hundreds of community and faith-based service providers began with this Committee when in July 1992, the House passed HR 5400, the Homeless Veterans Comprehensive Service Programs Act 1992. Later that year, the Senate also passed that legislation and it was signed into law by President George H. W. Bush on November 10, 1992.

The 102nd Congress acted upon a concern that veterans were appearing in a disproportionately high percentage among what was seem as an ever increasing number of Americans who were homeless. Congress also found that veterans were not able to access existing efforts to assist the homeless. Since the provision of that authorization required specific appropriation, which took another year to accomplish, VA did not offer its first Notice of Funding Availability until 1994 when we awarded 15 grants in September, 1994. Since that time each year, we have offered one or more notices of funding availability and today we now have more than 450 programs that have authorized 11,000 beds. As of September 2007, we have over 300 programs and 8,000 beds in service today. The remaining 3,000 beds are expected to come into service as soon as needed construction, renovation or repairs have been completed. VA must also complete its inspection of the physical facility to ensure that the program is ready to open with appropriate staffing and operational plans.

As you know, VA will soon announce awards under its latest notice of Funding Availability. We expect that we will be able to add 950 beds under this program. We have continued to offer new funding because of our great faith in the ability of many community providers to provide high quality services to veterans. Our goal, based upon this Congress' mandate, is to end chronic homelessness among veterans. We have made good strides in achieving that goal and we simply would not be able to do it without our community-based partners.

It is troubling when veterans or their families become homeless, especially in light of the service these brave men and women have made to our country. Our efforts, since the initial programs, have been to create positive partnerships. VA is committed to working with local communities to find those veterans through outreach programs. VA is committed to provide the care and services they need in order to facilitate their return to productive lives in their communities.

Our efforts are national as well as local. We partner with other Federal agencies, national, state, local, tribal Governments, local non-profits and faith based community providers. Each year, we provide health care services to more then 100,000 homeless veterans. We do not sit and wait for homeless veterans to come to us. We reach out to homeless veterans in shelters, soup kitchens, in parks, on the streets, and other places homeless persons frequent, including stand downs for homeless veterans. We have dedicated over 330 of our own staff who work collaboratively in communities across the country to find homeless veterans.

Mr. Chairman, we understand that this Committee is very interested in the effectiveness of our Homeless Grant and Per Diem program to serve veterans. The number of veterans being seen has increased and we have every intention to continue to increase the availability of transitional housing. We have rapidly increased the number of beds since last year. We expect to add nearly 2,700 before the end of the

year. Our performance measures to increase access and availability to both primary health care and specialty care within 30 and 60 days are showing great success. We are adding substance abuse counselors on-site of the community programs. In addition, we are increasing the number of veterans in community programs getting dental care, adding VA staff to work with community programs both in the form of reentry specialists working with veterans returning from incarceration, and fulltime health care network coordinators. These efforts are increasingly showing positive results.

In Fiscal Year 2006, VA provided transitional housing services to nearly 15,500 homeless veterans. This year, we anticipate that before the end of this Fiscal Year, we will serve more than 18,000 veterans. We anticipate that the number of veterans will continue to increase as programs already approved begin to provide direct services.

We have been closely monitoring and aggressively reaching out to ensure that those men and women who have served in the war in Iraq and Afghanistan are seen and offered appropriate services. During the past 3 years, we have seen more than 1,500 veterans who served in Iraq and Afghanistan through our outreach efforts and more than 400 have sought our assistance and been placed in a VA or VA supported community based treatment program.

As the Committee knows, VA can provide up to $31.30 for each day of care a veteran receives in a Transitional Housing program approved under VA's Homeless Providers Grant and Per Diem Program. We are aware that there are concerns about how we make payments to providers under the Grant and Per Diem Program, and that as a result of these concerns, H.R. 2699 was introduced to make a number of amendments to the program. Although the Department transmitted our views on H.R. 2699 to Congress on August 19, 2007, I would like to take advantage of this opportunity to discuss VA's position on the different provisions of the bill.

Section 1 of that bill would eliminate the statutory offset for other, outside sources of income when calculating the amount of a grantee's per diem payment. While we support this provision and appreciate the need for such a measure, we remain concerned that H.R. 2699, as written, could result in a grantee-provider receiving more than 100 percent of its costs for furnishing services to homeless veterans. We therefore recommend that Congress amend that provision to ensure safeguards to prevent such an occurrence.

Section 2 would require the Secretary to carry out a demonstration program in at least three locations for the purpose of identifying members of the Armed Forces on active duty who are at risk of becoming homeless after they are discharged or released from active duty. The demonstration program would also have to include the provision (either directly or by contract) of referral, counseling, and supportive services to help those members, upon becoming veterans, from becoming homeless. Section 2 would further require the Secretary to consult with the Secretary of Defense and other appropriate officials in developing and implementing the criteria for identifying those members who are at-risk of becoming homeless. Finally, Section 2 would authorize the demonstration program up to September 30, 2011, and it would also authorize $2 million to be appropriated to carry out the program.

VA supports Section 2. Research and related literature in this area suggest that prevention activities may be of value in identifying high-risk individuals and preventing them from becoming homeless. The challenge, of course, is in our ability to consult with others and, to identify criteria that can be used to successfully identify those service members who are at high-risk of becoming homeless once they leave the service. The demonstration program would help to add evidence to the current body of research and help us to determine whether this type of approach is effective in reducing the incidence of homelessness among recently discharged veterans.

The cost of Section 2, if enacted, would be insignificant and absorbed within the current budget.

Section 3 would extend, until September 30, 2011, VA's current program of referral and counseling for veterans who are transitioning from certain institutions and who are at risk for homelessness and will eliminate the program's demonstration status. Section 3 would also expand the program to include at least six more locations, thereby requiring a minimum of 12 sites.

VA defers to the views of the Department of Labor (DOL), which administers this program. DOL's staff advise us that they believe that the Incarcerated Veterans Transition Program pilot stage played an important and successful role in reducing recidivism among transitioning veterans who have been incarcerated.

Section 4 would authorize grants awarded under the Homeless Providers Grant and Per Diem Program to be used by service centers to meet staffing requirements.

VA supports Section 4 in principle. However, we recommend that the bill be modified so that funding is based on increased per diem payments rates for the service center, not provided to the center in the form of a grant.

Section 5 would require the Secretary to take appropriate actions to ensure that the Domiciliary Care programs are adequate, in terms of capacity and safety, for women veterans.

VA supports Section 5. VA has increased, and will continue to increase, the development of women specific residential treatment programs in VA's domiciliary program. This focus will include efforts to develop new programs for women veterans, along with improving therapeutic environments and clinical approaches in existing residential program.

VA, along with our partners, continues to make progress in prevention and treatment of homeless veterans. We firmly believe that one homeless veteran is too many. The brave men and women who have served and continue to serve deserve no less.

Mr. Chairman, this concludes VA's formal statement. We welcome the opportunity to respond to any questions you or Members of the Subcommittee may have.

Prepared Statement of Ronald F. Chamrin, Assistant Director, Economic Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's view on the Department of Veterans Affairs (VA) Grant and Per Diem (GPD) program.

The Fiscal Year (FY) 2006 Department of Veterans Affairs Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) report estimates that there are nearly 200,000 veterans that are homeless at any point in time. According to the February 2007 Homeless Assessment Report to Congress (U.S. Department of Housing and Urban Development 2007), veterans account for 19 percent of all homeless people in America.

Since 2001, approximately 300,000 servicemembers are becoming veterans every year. This large influx of veterans, some of whom have high risk factors of becoming homeless, is unnerving. The mistake in incorrectly failing to recognize the increase in homelessness amongst Vietnam veterans in the late 1970's and early 1980's cannot be made again.

According to the Urban Institute report in relation to the 1980's spike in homeless veterans (Homelessness: Programs and the People They Serve, Findings of the National Survey of Homeless Assistance Providers and Clients): ". . . some observers felt that the problem was a temporary consequence of the recession 1981–1982, and would go away when the economy recovered, while others argued that the problem stemmed from a lack of affordable housing and that homeless clients were simply a cross section of poor Americans." This 2000 study stated that of current homeless veterans: "21 percent served before the Vietnam era (before August 1964); 47 percent served during the Vietnam era (between August 1964 and April 1975); and 57 percent served since the Vietnam era (after April 1975). Many have served in more than one time period."

In order to prevent a national epidemic of homeless veterans in the upcoming years, measures must be taken to assist those that are chronically homeless. Steps must also be taken to prevent the future homelessness of veterans and their families.

Therefore, The American Legion strongly supports funding the Grant and Per Diem Program for a 5-year period (instead of annually) and supports increasing the funding level to $200 million annually.

The American Legion Homeless Veterans Task Force

The American Legion coordinates a Homeless Veterans Task Force (HVTF) amongst its 55 departments. Our goal is to augment existing homeless veteran providers, the VA Network Homeless Coordinators, and the Department of Labor's Homeless Veterans Reintegration Program (HVRP), Veterans Workforce Investment Program (VWIP), Disabled Veterans Outreach Personnel (DVOPs) and Local Veterans Employment Representative (LVERs). In addition to augmentation, we then attempt to fill in the gaps where there is no coverage. Each of The American Legion's Departments contains an HVTF Chairman and an employment Chairman. These two individuals coordinate activities with The American Legion's local posts within their state. The three-tiered coordination of these two chairmen and numer-

ous local posts attempt to symbiotically assist homeless veterans and prevent future homelessness.

The American Legion has conducted training with the assistance of the National Coalition for Homeless Veterans (NCHV), DOL–VETS, Project Homeless Connect, and VA on how to apply for Federal grants in various assistance programs, most notably the "Stand Down" and Grant and Per Diem programs. It is our goal to assist the Grant and Per Diem program by enabling individual posts and homeless providers to use The American Legion as a force multiplier. We may not have the job-specific expertise in the fields of social work and mental health, but we do have 2.7 million volunteers with an impressive network of resources within their communities.

The American Legion augments homeless veteran providers with transportation, food, clothing, cash and in-kind donations, technical assistance, employment placement, employment referral, claims assistance, veterans' benefits assistance, and in some cases housing for homeless veterans. The American Legion department service officers are accredited representatives that assist homeless veterans with their VA compensation and pension claims, and are fierce advocates for assuring that all VA benefits are afforded to the unfortunate homeless veterans that they may encounter.

Potential Homeless Veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)

OEF/OIF veterans are at high risk of becoming homeless. Combat veterans of OEF/OIF and the Global War on Terrorism (GWOT) in need of assistance are beginning to trickle into the nation's community-based veterans' service organizations' homeless programs. Already stressed by an increasing need for assistance by post-Vietnam Era veterans and strained budgets, homeless services providers are deeply concerned about the inevitable rising tide of combat veterans who will soon be requesting their support.

Since 9/11, over 800,000 American men and women have served or are serving in a war zone. Rotations of troops returning home from Iraq are now a common occurrence. Military analysts and Government sources say the military deployments, then the reintegration of combat veterans into the civilian society, is unlike anything the Nation has experienced since the end of the Vietnam War.

The signs of an impending crisis are clearly seen in VA's own numbers. Under considerable pressure to stretch dollars, VA estimates it can provide assistance to about 100,000 homeless veterans each year, only 20 percent of the more than 500,000 who will need supportive services. Hundreds of community-based organizations nationwide struggle to provide assistance to as many of the other 80 percent as possible, but the need far exceeds available resources.

VA's HCHV reports 1,049 OEF/OIF era homeless veterans with an average age of 33. HCHV further reports that nearly 65 percent of these homeless veterans experienced combat. Now receiving combat veterans from Iraq and Afghanistan daily, VA is reporting that a high percentage of those casualties need treatment for mental health problems. That is consistent with studies conducted by VA and other agencies that conclude anywhere from 15 to more than 35 percent of combat veterans will experience some clinical degree of PTSD, depression or other psychosocial problems.

Homeless Women Veterans and Children

Homeless veteran service providers' clients have historically been almost exclusively male. That is changing as more women veterans, especially those with young children, are seeking assistance. Access to gender-appropriate care for these veterans is essential.

The FY 2006 VA CHALENG (Community Housing Assessment, Local Education and Networking Group) report states, "Homeless providers continue to report increases in the number of homeless veterans with families (i.e., dependent children) being served at their programs. Ninety-four sites (68 percent of all sites) reported a total of 989 homeless veteran families seen, with Los Angeles seeing the most families (156). This was a 10 percent increase over the previous year of 896 reported families. Homeless veterans with dependents present a challenge to VA homeless programs. Many VA housing programs are veteran-specific. VA homeless workers must often find other community housing resources to place the entire family—or the dependent children separately. Separating family members can create hardship."

To assist women and veterans with families, The American Legion supports adequate funding for all domiciliary programs for all qualified veterans.

VA Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act 1992, Public Law 102–590. The Grant and Per Diem Program is offered annually (as funding permits) by VA to fund community agencies providing service to homeless veterans. VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans. There was an initial lag in the congressional authorization and appropriations for this program that delayed the delivery of funding 2 years after the initial legislation passed and only 15 grants were awarded. We have observed that the staff of the program has been working diligently and should be commended, but the central office staff could use additional members to expand the program to reach even more participants.

The current level of 300 programs and 8,000 beds is not enough to assist 200,000 homeless veterans. Reports of an additional 3,000 beds to come into service as soon as needed construction, renovation or repairs have been completed will bring the total to 11,000 or about 5 percent capacity of all homeless veterans.

Funds are available for assistance in the form of grants to provide transitional housing (for up to 24 months) with supportive services. Funds can also be used for supportive services in a service center facility for homeless veterans not in conjunction with supportive housing, or to purchase vans. VA can provide up to $31.30 for each day of care a veteran receives in a transitional housing program approved under VA's Homeless Providers Grant and Per Diem (GPD) Program. This token amount is far too little to fully assist a single veteran. Finally, all providers must justify that their costs are attributed to veterans.

The American Legion is concerned with the ebb and flow of the homeless veteran population and assert that measures should be enacted that allows a provider to always maintain a space for a homeless veteran. Due to the transient and drifting nature of chronically homeless veterans, seasonal weather changes (allowing more homeless veterans to venture outside), and other factors, there are periods when GPD providers may have an empty bed. If a provider has an empty space dedicated for a homeless veteran under the program and (due to factors out of their control) a bed remains empty for a period of time, they have occasional difficulty justifying the grant and therefore may be penalized. However, there are many instances in which a random appearing homeless veteran requires their assistance and a bed must always be ever ready.

Unfortunately, we have observed that many homeless veteran providers choose not to apply for funding from this program due to difficult mechanisms. As stated above, the accounting process required for reimbursement is in constant flux during the year and the strain of accurately reporting is laden on small community-based providers. Additionally, there are other Federal programs that can provide monetary assistance to homeless veterans, yet the GPD does not allow these funds to be used as a match for VA programs. This often discourages participation. However, other Federal programs do allow VA funds to be used as a match. VA's GPD program requires unique flexibility due to the nature of the funding, homeless veteran providers, and homeless veterans.

VA reports success in their performance measures to increase access and availability to both primary health care and specialty care within 30 and 60 days. Short-term assistance (30 and 60 days) is imperative in order to prevent chronic homelessness. Many times, a veteran may be in transition due to loss of a job, a medical issue, poor finances, or some other factor and only requires a short-term transitional shelter that can be provided by the GPD program. In FY 2006, VA reported that they provided transitional housing services to nearly 15,500 homeless veterans and expects to assist 18,000 veterans for FY 2007. It is imperative that these numbers continue to increase and be adjusted to meet demand; the consequences will be a stagnant, steady number of homeless veterans rather than a decrease of the number of homeless veterans.

Departments of Housing and Urban Development—Veterans Affairs Supportive Housing (HUD–VASH) Homeless Program

The American Legion advocates for increased funding for the Grant and Per Diem program and recently adopted a resolution to require mandatory funding for the Departments of Housing and Urban Development (HUD)-Veterans Affairs (VA) Supportive Housing (HUD–VASH) Homeless Program.

The American Legion supports funding for vouchers for the HUD–VASH Program be set aside and transferred to the Secretary of the Department of Veterans Affairs from amounts made available for rental assistance under the Housing Choice Voucher program. The Homeless Veterans Comprehensive Assistance Act of 2001

(P.L. 107–95) codified the HUD–VASH Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders. Under the HUD–VASH Program, VA screens homeless veterans for program eligibility and provides case management services to enrollees. HUD allocates rental subsidies from its Housing Choice Voucher program to VA, which then distributes them to the enrollees. A decade ago, there were approximately 2000 vouchers earmarked for veterans in need of permanent housing. Today, less than half that amount is available for distribution.

The Veterans Benefits, Health Care, and Information Technology Act of 2006, P.L 109–461, re-authorizes appropriations for additional rental assistance vouchers for veterans. In FY 2007, there will be 500 vouchers available for veterans and increased to 2,500 by FY 2011. At a time when the number of homeless veterans on any given night is approximately 200,000, the need for safe, affordable, and permanent housing is imperative. The Senate passed its fiscal 2008 Transportation-Housing spending bill (HR 3074) that funds programs at the Department of Transportation and the Department of Housing and Urban Development.

The House FY 2008 Transportation, Housing and Urban Development, and Related Agencies (THUD) appropriations bill, H.R. 3074, which passed the House on July 24, includes funding for incremental vouchers, specifically targeted to the non-elderly disabled population and homeless veterans. The bill provides $30 million for these vouchers. Of the incremental vouchers provided, 1,000 vouchers are to be provided for homeless veterans, in accordance with the HUD–VASH Program.

The Senate recently passed the THUD appropriations bill, which provides $75 million for new vouchers for the HUD–VASH Program. Funding, if enacted, should be sufficient to provide assistance for 6,000 vouchers affecting approximately 8,000 to 10,000 homeless veterans.

Census of Homeless Veterans

The VA CHALENG program, NCHV, HUD and numerous homeless veteran providers have all collaborated to make rather accurate estimates on the number of homeless veterans on the street each night. This number, approximately 200,000 each night, is a travesty. Because of the numerous systems in place to attempt to count the number of homeless veterans, additional funding should be directed to programs assisting and preventing homeless veterans and not entirely to assist a census program in counting homeless veterans. Funding would be better spent on programs and not just exclusively on counting.

CONCLUSION

The Homeless Grant and Per Diem program is effective and should be continued but augmented with HUD–VASH Program vouchers. With 300,000 servicemembers becoming veterans each year and the increased visibility and outreach of all veteran programs administered by VA, the availability of transitional housing must be increased. Our observations have shown that when the GPD program is allocated money, they are successful in distributing grants and administering their program and are only limited by the total dollar amount of funds available.

The American Legion looks forward to continue working with the Subcommittee to assist the nation's homeless veterans and to prevent future homelessness. Mr. Chairman and Members of the Subcommittee, this concludes my testimony.

POST HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
October 5, 2007

Honorable Gordon Mansfield
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Mansfield:

On Thursday, September 27, 2007, Peter Dougherty, Director, Homeless Veterans Programs, testified before the Subcommittee on Health on the U.S. Department of Veterans Affairs (VA) Homeless Grant and Per Diem program. In September 2006, the VA Office of Inspector General (OIG) issued a report, *Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program.* The Government Accountability Office (GAO) also conducted a review in 2006. As a follow-up to the hearing and the reports, I request that Mr. Dougherty respond to the following questions in written form for the record:

1. Has VA evaluated the benefits of establishing a centralized office of appropriately trained staff that conduct and ensure the quality of financial assessments of GPD providers? If so, what were the results of the evaluation?
2. Have GPD program staff received training that explains the difference between donations and discounts and emphasizes that provider funding can include nations but cannot include discounts received when purchasing goods or services? How is this training translated to the field?
3. The IG report recommended that the Under Secretary for Health review the financial oversight of GPD providers to ensure that per diem rates are accurately established and incurred cost reviews are properly conducted. VHA agreed to address this issue by obtaining an advisory and assistance contractor to review existing policies and procedures and to make recommendations to improve policies and procedures and financial oversight of the GPD program. What is the status of the contractor's review and what are the preliminary findings and recommendations? What specific steps have been taken to improve financial oversight of the program? The target date for full implementation of the recommendations of the contractor is January 2008. Will this date be met and if not, why and what is the new target date?
4. Of the 122 GPD Liaison positions that were funded, how many positions are currently filled? When will the remaining positions be filled? What are the specific responsibilities of the GPD Liaisons and has the Handbook been revised to reflect these responsibilities? What specific training do the liaisons receive and have they all been trained? How does VA measure the effectiveness of the training?
5. Of 21 full-time Network Homeless Coordinator positions that have been funded, how many are currently filled? When will the remaining positions be filled? What are the specific responsibilities of the Network Homeless Coordinators? How has VHA specifically revised inspection procedures to ensure that GPD providers receive timely feedback on the inspection and management of their programs?
6. The September 2006 GAO report, *Homeless Veterans Programs Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program,* made the following two recommendations: (1) To aid GPD providers in better understanding the GPD policies and procedures, we recommend that VA take steps to ensure that its policies are understood by the staff and providers who are to implement them. (2) To better understand the circumstances of veterans after they leave the GPD program, we recommend that VA explore feasible and cost-effective ways to obtain such information, where possible using data from GPD providers and other VA sources. What actions has VA taken to respond to these recommendations?

The attention to these questions by the witnesses is much appreciated, and I request that they be returned to the Subcommittee on Health no later than close of business, 5:00 p.m., Friday, November 2, 2007. If you or your staff have any ques-

tions, please call Dolores Dunn, Republican Staff Director for the Subcommittee on Health, at 202–225–3527.

Sincerely,

Jeff Miller
Ranking Member

Questions for the Record
Hon. Jeff Miller, Ranking Republican Member
Subcommittee on Health

House Committee on Veterans' Affairs
September 27, 2007
VA Homeless Grant and Per Diem Program

Question 1: Has VA evaluated the benefits of establishing a centralized office of appropriately trained staff that conduct and ensure the quality of financial assessments of GPD providers? If so, what were the results of the evaluation?

Response: The Department of Veterans Affairs (VA) has hired a contractor to evaluate the benefit of establishing a centralized office and to evaluate other initiatives that can improve the providing of per diem payments. The recommendations provided through the contractor will address whether centralization of per diem rate determinations is beneficial and, if so, recommendations would follow regarding the resources required to make these per diem determinations in accordance with regulations and statute. This evaluation should be completed in December 2007.

Question 2: Have GPD program staff received training that explains the difference between donations and discounts and emphasizes that provider funding can include donations but cannot include discounts received when purchasing goods or services? How is this training translated to the field?

Response: VA does not provide training to the Grant and Per Diem (GPD) program staff on the difference between donations and discounts, as VA clinical staff are not required to understand these differences. VA has hired and relies on an auditor to makes determinations on GPD capital invoices submitted for reimbursement. Included as part of the auditor's review is whether the required match for capital expenditures is a donation or discount. Providers are required to call the auditor to participate in budget reviews before capital funds are requested; information regarding donations and discounts is given to the provider at that time and the auditor advises providers accordingly. It is a concept that VA's auditor and the grantees billing VA must understand. Grantees are to participate in budget reviews before capital funds are requested. We feel that it is far more effective to consolidate the information from a single source rather than have hundreds of VA employees respond to inquiries.

Question 3: The IG report recommended that the Under Secretary for Health review the financial oversight of GPD providers to ensure that per diem rates are accurately established and incurred cost reviews are properly conducted. VHA agreed to address this issue by obtaining an advisory and assistance contractor to review existing policies and procedures and to make recommendations to improve policies and procedures and financial oversight of the GPD program. What is the status of the contractor's review and what are the preliminary findings and recommendations? What specific steps have been taken to improve financial oversight of the program? The target date for full implementation of the recommendations of the contractor is January 2008. Will this date be met and if not, why and what is the new target date?

Response: Recommendations under the advisory and assistance contract are pending. The contractor initiated work during October 2007, and continues to evaluate the feasibility of various methods that could ensure that per diem rates are accurately established and incurred cost reviews are properly conducted. It is expected that the target date for implementation of the recommendations will be met; however, full implementation may depend on the extent of the additional resources needed. VA has taken specific steps to increase the likelihood of the accuracy of per diem rate determinations by standardizing forms and allowing providers to input data on the Internet.

Question 4: Of the 122 GPD Liaison positions that were funded, how many positions are currently filled? When will the remaining positions be filled? What are the

specific responsibilities of the GPD Liaisons and has the Handbook been revised to reflect these responsibilities? What specific training do the liaisons receive and have they all been trained? How does VA measure the effectiveness of the training?

Response: Presently 111 of the 122 funded GPD liaison positions filled. The Veterans Health Administration (VHA) is recruiting for the remaining vacancies. The GPD liaison is responsible for: providing services to, and oversight of, the GPD-funded community-based programs; verifying the veteran status and eligibility of program participants and verifying admission and discharge dates of program participants; collecting and submitting GPD-funded program participant data; complying with criminal conflict of interest laws and *Executive Branch Standards of Conduct;* and providing oversight of GPD-funded program participants' care. The responsibilities of the GPD liaison are reflected in the VHA Handbook 1162.01 *(Grant and Per Diem Program Handbook)* which has been revised and was published August 8, 2007.

VHA provides face-to-face training to GPD liaisons. During fiscal 2007 two such training sessions were provided. VHA also developed an online training program for GPD liaisons which provides information about the GPD program and the role and responsibility of the liaison. The effectiveness of liaison training is evaluated through post-training surveys and by follow up activities conducted by VA Employee Education Service.

Question 5: Of 21 full-time Network Homeless Coordinator positions that have been funded, how many are currently filled? When will the remaining positions be filled? What are the specific responsibilities of the Network Homeless Coordinators? How has VHA specifically revised inspection procedures to ensure that GPD providers receive timely feedback on the inspection and management of their programs?

Response: All 21 of the full-time network homeless coordinator positions have been filled. Each network homeless coordinator has Veteran Integrated Services Network (VISN)-level responsibility for oversight and monitoring of the GPD programs in their VISN. The responsibilities of the network homeless coordinator include; participating in the initial and annual inspections of GPD-funded programs; reviewing copies of the completed initial and annual re-inspections in the VISN, and ensuring completeness; reviewing the medical centers' plans of correction that have been developed as a result of inspection deficiencies noted in GPD-funded programs and tracking follow-up activities associated with the deficiencies; ensuring the annual re-inspections of GPD-funded programs are submitted timely and in the proper format and are reviewed and approved by the VA Medical Center Director; forwarding reports regarding the status of each inspection package for their VISN; ensuring GPD-funded community programs are monitored and evaluated as prescribed by established protocols; working with GPD liaisons and medical center quality management staff to develop risk management and reporting systems for GPD-funded programs; reviewing GPD critical incidents and initiating appropriate investigation and follow-up activities in collaboration with the medical center; providing regular reviews of GPD liaison clinical and administrative documentation to ensure compliance with GPD policies and procedures; monitoring liaison follow-up of GPD-funded program clinical care and administrative issues; providing support, guidance, and advice to GPD liaisons.

VA has revised the GPD Handbook to include a policy that GPD liaisons are required to provide the final inspection report to the GPD provider. Under the new procedures the finalized inspection form will be signed by both the GPD liaison and GPD provider.

Question 6: The September 2006 GAO report, Homeless Veterans Programs Improved Communications and Follow-up Could Further Enhance the Grant and Per Diem Program, made the following two recommendations: (1) To aid GPD providers in better understanding the GPD policies and procedures, we recommend that VA take steps to ensure that its policies are understood by the staff and providers who are to implement them. (2) To better understand the circumstances of veterans after they leave the GPD program, we recommend that VA explore feasible and cost-effective ways to obtain such information, where possible using data from GPD providers and other VA sources. What actions has VA taken to respond to these recommendations?

Response: The GPD program has initiated a number of actions to help ensure policies are understood by staff and providers. GPD liaison face-to-face training sessions were held in March and August of 2007. These 2-day training sessions included an overview of the GPD program, the rules and regulations, and monitoring and inspection procedures. Additionally, monthly conference calls were conducted

with liaisons through 2007. The minutes of these calls were placed on the GPD liaison Web page. Web-based liaison training was developed and is currently available nationally, and a new VHA Handbook was published and distributed to VA network homeless coordinators and GPD liaisons. Additionally, the GPD liaison Web site was revised and expanded to include, along with the regulations, handbooks and legislation, template letters, and guidance on reviewing scope and site changes.

Providers' conference calls were held for the "new grant awardees" (January, February, and June 2007) and for current operational programs (December 2006, June and August 2007). A *Providers Web Page* was developed and is currently posted on the Internet. The Web site includes revised capital grant and per-diem-only grant recipient guides, conference call minutes, program rules and regulations, methods for calculating per diem rates, relevant public laws, and links to other helpful Web sites.

VA has invested in a total of nine outcome studies of its homeless programs, five of which are either under analysis or currently collecting data. We have completed three outcome studies of our homeless programs which consistently showed 60–80 percent of veterans housed at 8–12 month follow-up. In addition, we have completed data collection on four outcome studies of homeless programs involving 2,500 homeless veterans that include follow-up of veterans after completion of the program. Finally, two additional programs are underway, one evaluating a critical time intervention, and the other, outcomes for women's programs. Together, these programs represent an investment of several million dollars in evaluating and improving outcomes.

VA believes that the most feasible and cost-effective approach to understanding the circumstances of veterans after they leave the GPD program would be to complete analysis of these data that have already been collected and to determine the best approach to further data collection on the basis of the analysis of data already collected. Once on-going studies and analyses are completed, VA would have more information to make evidence-based decisions on whether to narrow the direction of follow up or, as suggested in the report, use more broad parameters such as information from existing data bases. While these efforts are in progress, we will explore the feasibility, limits, and utility of using existing health care performance measures and quality indicators, stratified on the basis of previous participation in homeless programs as a way to evaluate its continued engagement in health care.